STATE OF INDIANA)
) SS:
COUNTY OF DELAWARE)

IN THE DELAWARE COUNTY SUPERIOR COURT

CRAIG DUNN AND PHILIP WILEY, ET AL.,
Plaintiffs,

-v-

RJR NABISCO HOLDINGS CORPORATIONS, ET AL.
Defendants.

CAUSE NO. 18D01-9305-CT-06

VOLUME II

The deposition upon oral examination of JOSEPH MICHAEL SONGER, M.D., a witness produced and sworn before me, Sally B. Gerlach, RPR, CSR, Notary Public in and for the County of Marion, State of Indiana, taken on behalf of the Defendants at the offices of Medical Consultants, 2525 University Avenue, Muncie, Indiana 47303 on November 13, 1997, at 1:00 p.m. pursuant to the Indiana Rules of Trial Procedure.

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JOSEPH MICHAEL SONGER, M.D.
having been first duly sworn to tell the truth, the whole truth, and nothing but the truth took the stand and testified as follows:

DIRECT EXAMINATION
BY MR. WAGNER:

Q Doctor, as before in your previous deposition, if I ask you a question which you do not understand, will you tell me so that I can rephrase it and both of us can understand what I'm talking about?
A Yes, sir.
Q Your deposition in this case was taken on October 31, 1997, and it's been transcribed. Have you read that deposition?
A Yes, sir.
Q And have you read it from beginning to end?
A Yes, sir.
Q Is there anything in that deposition that you want to correct?
A Grammatical errors or --
Q I'm really not interested in grammatical errors, but I am interested in anything of substance that you believe is inaccurate?
A I found nothing there that was inaccurate to

my recollection.
Q Since your deposition was completed on the evening of October 31, 1997, how many times have you talked to plaintiffs' attorneys?
A Once.
Q And when was that?
A Today.
Q What time?
A 12:30.
Q Who was present?
A Jim, Greg, and Max.
Q And you, of course?
A And myself.
Q And no one else?
A No one else.
Q And what was the substance of the conversation that ensued during that meeting?
A It was just a matter of do I have any questions prior to finishing the deposition. And I asked questions if I should bring the deposition. And that was basically the nature of it.
Q Did you have any conversations with the plaintiffs' attorneys about the substance of

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your testimony either on October 31, 1997, or the substance of the testimony which you might give today?
A No, sir.
Q Did you review any documents or writings of any kind in that meeting?
A No, sir.
Q On the evening of October 31, 1997, when your deposition was adjourned, you remained in the room for awhile, did you not, after the defendants' attorneys left the room, this room in which your deposition is being taken today? And just to follow up on that, on that evening did you have any conversations with plaintiffs' attorneys about your deposition?
A I do not remember actually that we met other than just the day is over. You'll be finishing up. We will work with you as to when that has to be done. There was nothing specific that I recall.
Q Do you recall having any conversations of substance on that evening about your deposition testimony with plaintiffs' attorneys?

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A No, sir.
Q Do you recall discussing any documents on that evening with plaintiffs' attorneys?
A No, sir.
Q Have you done anything to prepare for the deposition which you are about to give today?
A I've reviewed the same material that I brought on the 31st. I've not done additional preparation.
Q Okay. And you reviewed the transcript of the deposition you gave on October 31st?
A Yes, sir.
Q If you will please get in front of you what's previously been marked during your deposition as Exhibit 56 which is the autopsy report. And that was a document that we were discussing when your deposition was adjourned on October 31st. Do you recall that?
A Yes, sir.
Q Were you present during that autopsy at any time?
A No, sir.
Q To your knowledge, was Dr. Turner present during that autopsy at any time?
A Not to my knowledge.
Q Was Dr. Kocoshis present during the autopsy, to your knowledge?
A I do not know.
Q Have you ever examined any of the tissue or specimens that were taken from Mildred Wiley's body at the time of that autopsy?
A No, sir.
Q Do you know Dr. Janusz Wolaniuk who performed the autopsy?
A By name I do not recall who that individual was. I do not have any independent recollection of him who he was.
Q So you don't know him personally?
A No, sir.
Q Do you know him to be a resident? Or, excuse me, do you know that he was a resident at the time of the autopsy in June 1991?
A Based on the signature on Exhibit 57, yes. He's listed as a resident.
Q Do you have any opinions about the quality of the autopsy as it's reflected in this report?

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A No, sir.
Q Directing your attention to the second page of the autopsy report under the section entitled "Lungs," do you see that?
A Yes, sir.
Q And in the fourth line there, there is a sentence that says -- it begins, "The lungs and the hilar nodes are not significantly anthracotic." Do you see that?
A Yes, sir.
Q Do you know what the word anthracotic means, or can you tell us what it means?
A I believe it's a reference to any black discoloration. I think it actually was originally related to anthracite coal, and I think the word anthracotic comes from that. And I think it's a nonspecific description as to whether there is any black discoloration of the lymph nodes which I believe could be a part of like someone that had lung disease from working in coal mines, I believe.
Q Now, this autopsy report, if we look at the third page, shows that it was dictated on June 24, 1991, correct, either dictated or

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typed on that date?
A Exhibit 56 you're saying?
Q Yes, sir, the third page. I'm talking really about -- let me rephrase the question.
A Okay, I'm sorry.
Q On the third page it appears that the gross examination dictation was either made on or typed on June 24, 1991?
A Yes, sir.
Q Correct?
A Yes, sir.
Q And then the other section, as you and I discussed before, has to do with the microscopic examination and the final pathologic diagnosis that's reflected on the next two or three pages, right?
A Yes, sir.
Q And if you go to page 5, it appears that that portion of the autopsy report was not dictated or typed until March 18, 1993. Do you know why that is so?
A I do not know why. I know that it's always a long time until you get a final path report back. I can't say -- nine months

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seems like a long time, but there is usually a long time before you get the final path report to share with the family or whatever you're using it for.
Q If you look at page 4 with me for just a moment, please.
A Yes, sir.
Q And do you see the section there entitled, "Pancreas"?
A Yes, sir.
Q And that's the section that deals with the microscopic evaluation of the pancreas or a section of the pancreas, correct?
A Yes, sir.
Q And it's reflected there that there was a parapancreatic lymph node that was replaced by metastatic tumor?
A Yes, sir.
Q Would you agree, Doctor, it would be unusual to have cancer in the parapancreatic lymph node without a primary cancer in the pancreas?
A No, I would not agree with that.
Q Would you agree, Doctor, that in connection with an autopsy of this kind that was

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performed that it would have been important to examine breast tissue microscopically in a patient with a greatly elevated CA 15-3 who was treated for breast cancer?
MR. YOUNG: I'll object to the characterization of the test results and counsel's conclusions.
A I don't know what the criteria would be for doing an autopsy with removal of the breast. I don't believe that is considered a standard part of the autopsy. So on what basis that decision is made, I don't know.
Q Well, I didn't ask you if you knew upon what basis the decision was made. I asked you whether or not in your professional opinion you would think that it would be important to examine the breast tissue microscopically in a patient with an elevated CA 15-3 who was treated for primary breast cancer?
A I think that would have been helpful in this case.
Q And would it have been especially helpful, Doctor, if the purpose was to find where the primary tumor was in Mildred Wiley?
A That could have ruled in or ruled out the

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breast.
Q This autopsy report does not indicate that there was or that she had present -- rather, Mildred Wiley, had an endobronchial tumor; does it?
MR. YOUNG: I'll object to the form of the question.
A I do not see that terminology used with regard to this pathology review.
Q You're familiar, Doctor, are you not, with the death summary that was written by Dr. Turner?
A Yes, I've read it.
Q Did you have any input into that death summary?
A No, sir.
Q Will you get in front of you please, Doctor, what's previously been marked as Exhibit 12. And I have in front of you the stack of your exhibits just to expedite things a bit.
A Yes, sir.
Q Now, that's a letter that is addressed to you dated November 23, 1992, from one of the plaintiffs' attorneys?
A Yes, sir.

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Q Plaintiffs' attorney being Joseph Young?
A Yes, sir.
Q And in that letter he told you in the opening paragraph that he represented Philip Wiley in his Worker's Compensation claim for the death of his wife, Mildred Wiley, correct?
A That is correct.
Q And he told you in the next sentence that Mr. Wiley believes that his wife's lung cancer was caused primarily by her exposure to secondhand cigarette smoke at the Veteran's Administration in Indianapolis where she worked as a nurse for over 18 years, correct?
A Yes, sir.
Q And in the last sentence of that first paragraph he told you that Dr. Turner strongly believed that Mrs. Wiley's lung cancer was caused by her exposure to secondhand smoke at the Veteran's Administration, correct?
A Yes, sir.
Q Did you discuss this letter with Dr. Turner after you received it?

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A I have no independent recollection if I discussed this letter with her.
Q Do you recall what you did with this letter after you received it? Withdraw the question. Do you recall what you did about this letter and -- let me withdraw that question, too, and let me focus your attention on the second paragraph which is a paragraph where Mr. Young says, "We are requesting a report from you that contains an accurate history, test results and findings, diagnosis and opinion on the causal relationship between Mrs. Wiley's death and her employment at the Veteran's Administration." And that request is actually repeated also on the second page in the second to the last paragraph. And I'll give you a minute just to look at that if you want to.
A Yes, sir.
Q Do you recall what you did, if anything, in response to this letter?
A I believe it was this letter that had led to my dictating a return letter to Mr. Young.
Q Okay. And we will look at those letters.

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Actually I think there was more than one.
And we will look at those letters in just a moment. Aside from the letters that you may have written to Mr. Young in response, what did you do, if anything, in regard to this letter and the request contained in it?
A I would have reviewed the information that I had at that point prior to sending him a return letter.
Q And by that information you mean what?
A The chart that we had generated here. The information from her hospitalization that we had in the chart here at Medical Consultants.
Q Anything else that you can recall you did?
A I don't recall anything specific other than the nature of the letter implied that I reviewed that material, and that's the basis I'm saying that. I don't recall specifically what I did.
Q In the third paragraph of Exhibit 12 on the first page Mr. Young tells you, "The Federal Worker's Compensation Board seems to have latched on to your report of January" -- is that 3 or 8, whatever it is -- "1992. In

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this report you advised that your impressions were" and he quotes them there. And then says on the second page, "They have used this information to deny Mr. Wiley Federal Worker's Compensation benefits. Perhaps you that you wrote" -- that is obviously a typo there. He probably meant to say, "Perhaps you wrote this down after being told that she was not a smoker. Perhaps you did not know of her constant exposure to secondhand smoke over the last 18 years of her life. The Veteran's Administration had no smoke ventilation system to protect its workers." Do you see that?
A Yes, sir.
Q Do you know why Mr. Young was suggesting that to you?
MR. YOUNG: I object. That calls for him to speculate.
Q Withdraw the question. Did you form any mental impressions as to why Mr. Young was suggesting that information to you?
MR. YOUNG: Same objection.
A No, I do not know the specifics of --

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Q After you received this letter dated November 23, 1992, did you discuss with Dr. Turner whether she strongly believed that Mrs. Wiley's long cancer was caused by her exposure to secondhand smoke at the Veteran's Administration as stated in the first paragraph of this letter?
A I do not recall any specific discussions with Dr. Turner. As we have mentioned before, the face sheet on the discharge summary included the diagnosis of metastatic adenocarcinoma of the lung secondary to secondhand smoke. I would have reviewed that before returning a letter. So I would have been familiar with that impression by Dr. Turner. But I don't recall any specific additional discussion about that.
Q Well, let's go to the next document chronologically that appears in your file, Doctor, that you've produced for us in this case. Would you get Exhibit 11 in front of you?
A Yes, sir.
Q Exhibit 11 is addressed to you, but the salutation states "Dear Theresa." Would

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that have been your secretary on January 11, 1993, the date of this letter?
A I do not remember --
Q All right.
A -- anyone named Theresa.
Q And in substance if you look at this letter, it says -- and this is a letter written by Mr. Joseph Young again, correct?
A Yes, sir.
Q And the letter says that, "Our service sent the enclosed letter to your office on November 23, 1992." That would be Exhibit 12; wouldn't it?
A Yes, sir.
Q And he says it's been brought to his attention that your office has no record receiving a letter, enclosed a copy and stated that the requested information is imperative to Mr. Wiley's Federal Worker's Compensation claim and wanted your prompt response. Did you see this letter shortly after it would have been received by your office, I should say?
A I presume that I did because the time sequence seems to relate to the fact that I

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did subsequently send a letter back, I believe.
Q And then if you look at Exhibit 13, do you know what Exhibit 13 is, Doctor?
A It appears to be a review of claims relative to, as it says, a causal link between employee's death and factors of her federal employment and a decision about what they --
Q Is it accurate to say, Doctor, that this is a written decision by a claims examiner on the claim by Philip Wiley for Worker's Compensation?
MR. YOUNG: I object. You're asking this witness what he knows or doesn't know is fine, but I think you're asking him to speculate, and the document speaks for itself.
Q Do you understand that that's what this document is, Doctor?
A That's what I understand it to be.
Q Can you tell me how this got into your file? This is one of the documents you produced for us; isn't it?
A This was in the folder that I had brought.
Q Right.

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A To the deposition.
Q This was one of the documents that you brought in response to the request for documents at the time of your first deposition on October 31, 1997, correct?
A Yes, sir.
Q Now, can you tell me how this document got in your file?
A No, sir.
Q As you sit here today, do you believe that document could have come to you from any source except from plaintiffs' attorneys?
A I do not recall seeing it until I began to review this case prior to my deposition. And so I have no opinion as to how it got there.
Q Exhibit 13 has certain marks on it, I guess I'll call them; is that right? Circles, ' marks?
A Yes.
Q Parentheticals?
A Right.
Q That someone has ascribed upon the document?
A Yes, sir.
Q Did you make those marks?

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A Yes, sir.
Q Do you know when you made them?
A Within the two weeks prior to my deposition that began on the 31st.
Q Prior to the time that you made the marks on Exhibit 13, do you recall making any use of or reading Exhibit 13?
A Not that I remember, not that I recall.
Q If we look at Exhibit 14, what is Exhibit 14? Withdraw the question. Exhibit 14 is another document that you produced for us out of your file on October 31, 1997, correct?
A Yes, sir.
Q What is Exhibit 14?
A It's a form from the U.S. Department of Labor relative to claim for compensation by widow, widower and/or children.
Q And how did you come into possession of that document?
A I do not know.
Q What use have you made of that document?
A None.
Q If you look at Exhibit 15, do you recognize Exhibit 15 as another document that you

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produced for us on October 31?
A Yes, sir.
Q How did that document get in your file?
A I do not know.
Q Do you see Dr. Turner's signature down there at the bottom or name down at the bottom?
A Yes, sir.
Q Did you get that from Dr. Turner?
A I do not recall.
Q Have you made any use of Exhibit 15?
A Just that I reviewed it prior to the deposition. I've made no use of it.
Q Look at Exhibit 16, please. The front side of Exhibit 16 is a copy of a newspaper obituary note on the death of Mildred Wiley, right?
A Yes, sir.
Q And on the back of Exhibit 16 there are some handwritten notes, correct?
A Yes, sir.
Q And those are your handwritten notes?
A Yes, sir.
Q When did you make those notes?
A Sometime in the two weeks prior to my deposition.

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Q Were you looking at anything when you made these notes? That is to say, are these notes of some document that you were looking at?
A No, sir.
Q What do these notes represent?
A I was just putting on paper what my thought processes would be relative to the differential diagnosis of this case.
Q So you wrote down on the left side the metastatic adenocarcinoma to various parts of the body?
A Yes, sir.
Q And on the right side, what does that represent?
A Lung versus breast and pancreas.
Q And by lung versus breast and pancreas, what were you indicating?
A Lung was the pathologic diagnosis that was given at the postmortem. As we have discussed, breast was in the differential at the time that I was seeing the patient. And pancreas was in the differential of an elevated CEA. And so I was just in my mind trying to formalize my thoughts.

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Q And in formalizing your thoughts, you were considering whether or not she had a lung primary, a breast primary or a pancreatic primary, correct?
A Those were the three that I have written down here.
Q Why is the newspaper obituary of Mildred Wiley in your file?
A It is standard for one of our employees to put such information in the chart. For one thing it includes the fact that this chart then becomes a nonactive chart. And so we have one person designated to read through obituaries. So I presume that's why this is in here.
Q So it's a matter of standard practice in your practice to clip obituaries from the newspaper that relate to your patients?
A Standard practice of Medical Consultants when there is a death.
Q Okay. Please look at Exhibit 8.
A Eight?
Q Yes, sir. Exhibit 8 is a letter addressed to plaintiffs' attorney, Joseph Young, dated January 22, 1993, correct?

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A Yes, sir.
Q Is that a letter that you wrote?
A It appears to be a letter that I dictated.
Q Do you know whether or not that letter was ever sent?
A No.
Q Is this a draft?
A I don't know how it relates --
Q Excuse me. I didn't mean to interrupt you. Just to make it easier, there are three such letters in your file; are there not?
A Yes, sir.
Q I mean, you've reviewed all the documents in your file, so you know that there are three letters in your file to Attorney Joseph Young, each one of which is different than the other, correct?
A I believe the two dated June 21st are the same except the --
Q The opening sentence?
A The date is off to the side.
Q Okay, all right. We will look at the other two in just a moment then. But as you sit here today, Doctor, do you recall that you sent Exhibit 8 to or mailed Exhibit 8 to or

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delivered Exhibit 8 to Attorney Young?
A I do not recall.
Q You don't recall one way or the other?
A I don't recall one way or other.
Q Do you recall having any discussions with Attorney Young about Exhibit 8?
A No, sir.
Q Did any attorney, including Attorney Young, have any input into the drafting of Exhibit 8?
A No, sir, not to my recollection.
Q In the last sentence of this letter you say, "I have no independent recollection of the patient or her case to add to the consultation or what I have reviewed in this dictation." Now the "her" you're referring to is Mildred Wiley, correct?
A That's correct.
Q And do you mean by that sentence, Doctor, that when you dictated this letter in January of 1993 that you did, in fact, have no independent memory of Mildred Wiley or her case aside and apart from the medical records themselves?
A That is true.

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Q All right. That letter is dated January 22, 1993. Let me ask the reporter to mark this as the next exhibit.
(Defendants' Exhibit(s) 58 marked for identification.)
Q This is actually also Exhibit 19 in Dr. Turner's deposition. I'll give you a moment to review that.
A Okay. I've read it.
Q Have you ever seen this document before today?
A Not to my recollection.
Q Do you know this to be a document dictated by and created by Dr. Turner?
A It's not signed by her but NCT --
Q Would indicate that?
A -- :DH would signify that it had been dictated and transcribed by DH.
Q She reports in the first paragraph that on May 3 she discussed this case with J.L. Repace. Do you see that?
A Yes, sir.
Q Did you ever have any conversations of any kind with J.L. Repace?
A No.

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Q Do you know who Mr. Repace is?
A No, sir.
Q In the next paragraph she states Mr. Repace stated this was a good case. He recommended that I talk to Mr. Richard Daner, D-A-N-E-R, who may in fact be a Mr. Daynard, D-A-Y-N-A-R-D. Did you ever have any conversations with a Richard Daner or Daynard?
A No, sir.
Q At the Northeastern University School of Law?
A Not to my recollection.
Q In the one, two, three, four, fifth paragraph in the third line she states he recommended that I talk to Dr. David Burns at San Diego. Did you ever have any conversations with Dr. David Burns?
A Not to my knowledge.
Q Did you have any conversations with Dr. Turner about her conversations with Mr. Repace? Let me just stop right there. The question is, Doctor -- I've confused you. The question is: Did you have any conversations with Dr. Turner about her

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conversations with Mr. Repace?
A Not that I remember.
Q The same question with respect to any conversations she had with Richard Daner or Daynard?
A Not that I remember.
Q Same question with respect to Dr. David Burns?
A Not that I remember.
Q In the second to the last paragraph she states, "I discussed the case with Mr. Tom Brown" who I can represent to you we have ascertained during Dr. Turner's deposition was really meant to be Mr. Tom Young who is an attorney in Indianapolis. And she states certain things about what he and his brother are willing to do and so forth. Did you have any conversations with Dr. Turner about her conversations with Attorney Tom Young?
A Not that I recall.
Q Will you look at Exhibit 17, please? Exhibit 17 is a document that you produced for us on October 31, 1997, from your file, correct?
A Yes, sir.

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Q And how did you come into possession of a copy of that document?
A I do not recall.
Q This document --
MR. YOUNG: Excuse me, counsel.
MR. WAGNER: Sure.
MR. YOUNG: Just so the record is clear, this Exhibit 17 to Dr. Songer's deposition already has a sticker for Exhibit 3 from Dr. Turner's deposition which was taken previously to Dr. Songer's deposition which would account for this being in the pack of materials, I think, because Dr. Turner's deposition of exhibits have been used interchangeably with Dr. Songer's deposition, I think.
MR. WAGNER: Well, in some cases that's true. In other cases it's not. The point being what?
MR. YOUNG: I just offer that as an explanation of how this came to be in here because it has a joint sticker on it. That's my only point.
Q Well, just so the record is clear, Doctor, Exhibit 17, Songer Exhibit 17, is a document

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that you had in your file, correct?
A I have no reason to say to the contrary. As I recall, we went through all of those reports that I brought with me to the deposition. I don't have an independent recollection of that sheet.
MR. YOUNG: You're right, Dick. One through 18 were the numbers that he brought in that folder with him on the first day.
MR. WAGNER: All right.
Q Now, the next question then about Songer Exhibit 17, Doctor, please, you've reviewed this document before today; haven't you?
A Yes, sir.
Q And you reviewed this document, in fact, in preparation for your deposition, correct?
A Yes, sir.
Q And it starts out by saying in the very first sentence, "A long discussion ensued throughout the afternoon. When I talked to Dr. Songer today, he stated he could not get up on a witness stand and state that this unequivocally was related to lung cancer because of an elevated CA15-3 which he

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obtained." Let's stop right there, okay? Do you recall having a long discussion with Dr. Turner on May 24, 1993?
A I have no independent recollection of that conversation.
Q Do you have any independent recollection of the conversations that Dr. Turner reports in this exhibit that she had with you?
A No, sir.
Q Do you recall talking to Dr. Turner on May 24, 1993, and stating you could not get up on a witness stand and state that this unequivocally was related to lung cancer because of an elevated CA15-3 which you obtained?
A I have no recollection of that discussion on that date.
Q As you sit here today, your testimony is you have no independent recollection of the meeting and discussion with Dr. Turner on May 24, 1993, that's related in this exhibit; is that what you're telling me?
A I do not recall a specific time that we sat down and talked that coincides with this dictation.

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Q Well, laying to one side for a moment the date of May 24, 1993, being the specific date that you may have met with and conversed with Dr. Turner as related in Exhibit 17, do you have a recollection of having a meeting with Dr. Turner that is discussed in this exhibit?
A My only recollection going back was just that in reviewing the case as I had gone over my discussions when I was seeing the patient and that I basically talk about the fact that the elevated serum tumor markers raised the possibility of breast cancer. And at that point in time, as I believe I said on the 31st, we had reason to think that the CA15-3 was a specific tumor marker for breast cancer. And I could envision having said that type of statement to her because it's similar to what I had stated in my own writing in the chart that was in the differential with an elevated CA15-3. So I would not deny that I would have told her that. I have no specific recollection of a time when we sat down and went over it.
Q Now, Doctor, I don't want you to speculate

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for me or guess that you may or may not have said the things that are related in this exhibit. My question is very specific. I want to know regardless of whether or not the May 24, 1993, date is the date on which you had the discussions and conversations with Dr. Turner related in this exhibit. I want to know if you have an independent recollection of the conversations with Dr. Turner in the matters that you may have interfaced with Dr. Turner about that are related in this exhibit?
A The answer is I have no independent recollection.
Q In or about this time frame, that is to say May, June, 1993 which is now about two years after Mildred Wiley's death, do you recall having any conversations with a Dr. Victor Roggli as is mentioned here in the first paragraph, fifth line, sixth line from the end?
A To my knowledge, I've never talked to this physician.
Q Did you ever discuss with Dr. Turner anything that she's said or to Dr. Roggli or

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anything Dr. Roggli said to her?
A Not to my recollection.
Q In the next paragraph, Dr. Turner describes a Dr. Triplett. Do you know a Dr. Triplett?
A Yes, sir.
Q Pardon me?
A Yes, sir.
Q Do you know Dr. Triplett personally?
A Yes, sir.
Q Tell us who Dr. Triplett is.
A He is on the pathology staff at Ball Memorial Hospital.
Q Have you had any conversations with Dr. Triplett about any matters pertaining to Mildred Wiley?
A No, sir.
Q Have you had any conversations with Dr. Triplett about any matters pertaining to this lawsuit?
A No, sir.
Q Did you have any conversations with Dr. Kocoshis during the time frame that Exhibit 8 was written?
A Not to my recollection.
Q Have you ever discussed Mildred Wiley's case

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with Dr. Kocoshis subsequent to the time Mildred Wiley died?
A No, sir, not to my recollection.
Q Okay. Now focus with me just a moment please on the third to the last paragraph on the first page. Again, I know you told me you don't have an independent recollection of these matters, but I want to ask you a couple of questions anyway. She says in that paragraph, "In talking with Dr. Tom Kocoshis I questioned who else would be able to look at the slides. He suggested Dr. Lester Wold," W-O-L-D, a pathologist at the Mayo Clinic. Did you ever talk to Dr. Wold?
A No, sir.
Q Did you ever talk to Dr. Turner about any conversations she may have had with Dr. Wold?
A Not to my recollection.
Q She then says, "I then talked to Dr. Songer and we had a long discussion. What we would like to do is this." And then she relates in the next couple of paragraphs some things of what we would like to do. Do you

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remember having any such discussion with Dr. Turner?
A No, sir.
Q In paragraph No. 1 she says, "We are going to review the chart to see what his frame of mind was and why we didn't start aggressive chemotherapy." The "we," I take it, being -- again, I know you didn't write this. You have no recollection of it, but "we" being you and she, Dr. Turner, to see what your frame of mind was. Do you recall reviewing the chart with Dr. Turner on or about this time to see what your frame of mind was and why you did not start aggressive chemotherapy?
A No, sir.
Q The next sentence says, "If his frame of mind at that time was the fact that we were most likely adenocarcinoma, that would help him make a decision about what he could testify to." Again, you didn't write this. You had no independent recollection of it, but assuming that the "he" and the "his" that she's referring to is you, Dr. Songer, do you recall any such matters being

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discussed with Dr. Turner as to what your frame of mind was at that time as to whether it was most likely adenocarcinoma that would help you to make a decision as to what you could testify to?
A No, sir.
Q That exhibit is dated May 24. Let me ask the reporter to mark this as the next Exhibit 59.
(Defendants' Exhibit(s) 59 marked for identification.)
Q I'll give you a minute, Doctor, to review that exhibit.
A Is this the same exhibit as 18?
Q Is it?
MR. YOUNG: Yes, it is.
Q Okay.
MR. YOUNG: Well, there is a mark on 18 that isn't on 59.
Q Could I see those just a minute, Doctor? Okay. For the record let me withdraw Songer Exhibit 59 so we don't have confusion here, and I'll ask you now, Doctor, to look at Exhibit 18. Exhibit 18 is a document that you produced for us on October 31, 1997?

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A Yes, sir.
Q So it's a document that came from your files?
A Yes, sir.
Q And do you know how you came into possession of Exhibit 18?
A No, sir.
Q Exhibit 18 is another dictation by Dr. Turner, correct?
A Yes, sir.
Q And it's dated May 25, 1993?
A That is correct.
Q And the opening sentence says, "Dr. Songer and I reviewed the patient's chart and discussed it at length today." Do you remember doing that with Dr. Turner on or about May 25, 1993?
A No, sir.
Q She says here in the third sentence, "The question arose as to whether or not we would be dealing with breast cancer versus lung cancer. Dr. Songer suggested I contact Dr. Dan Hayes at the Department of Breast Medicine, Dana-Farber Cancer Institute." The telephone number and address is given.

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Do you recall discussing with and suggesting to Dr. Turner that she contact Dr. Dan Hayes?
A I recall to the extent that I did contact Dr. Dan Hayes. I do not remember a time when we sat down and went over the chart. But I do remember calling Dr. Dan Hayes to ask him about CA15-3.
Q Would you have called Dr. Hayes at or about the time that this memorandum was written or refers to May 25, 1993?
A I have no independent recollection as to when I called him.
Q Well, the memorandum is dated May 25, 1993, and relates in the next couple of sentences that, "Dr. Songer did discuss this case with Dr. Hayes. He felt that he has seen 80 percent of lung cancers being where the CA15-3 is elevated," et cetera. She's apparently relating a conversation that you had with Dr. Hayes, correct?
A To my knowledge, I'm the only one that talked to Dr. Hayes.
Q Dr. Turner did not?
A As far as I know --

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Q To your knowledge?
A -- she did not talk to him.
Q Now, when you talked to Dr. Hayes, tell me the substance of what you said to him and what he said to you.
A I cannot tell you the exact conversation. I asked him about specificity of the CA15-3 in a case such as this case and to what extent he would consider the CA15-3 to be a diagnostic test. Meaning that if it's elevated, then that confirms breast cancer.
Q What did he say to you?
A My recollection is that he said that it's a nonspecific test. In fact, he commented on whether or not this test was being paid for by insurance companies in Indiana because although he was in on developing the test at the Dana-Farber, that the insurance companies would not pay for that test in Massachusetts. And he was surprised that we had access to that test. And he said, as best as I can recall, it's a very nonspecific marker for epithelial malignancy and that does not impact either way on what this case was related to. I do not remember

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percentages. I just remember the statement that this is an epithelial marker that's nonspecific. And it's seen in lung cancer, and it's certainly not specific to breast cancer.
Q What else did you and Dr. Hayes talk about that you can recall?
A As I remember, he was in a hurry to meet a plane, and it was a very brief conversation.
Q You've now related to me the substance of everything you can recall that you talked about with Dr. Hayes?
A Yes, sir.
Q Following your conversation with Dr. Hayes, you would have related to Dr. Turner that conversation. Do you recall doing so?
A I don't recall doing so.
Q Why were you calling Dr. Hayes?
A He is from Indiana. He is an acquaintance of one of my associates who knew that he was one of the investigators that had actually developed the test. In fact, we are told, I believe, that the 3 designation there is actually his serum, that he was involved with developing the test. So since it was a

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contact, he would be the logical person to call.
Q Okay. You wanted to discuss with Dr. Hayes some questions you had about the CA15-3 test?
A Yes, sir.
Q Why did you want to discuss with Dr. Hayes questions you had about the CA15-3 test at this time in about May of 1993?
A Well, as I believe has been stated before, the only objective information that I had at that point that would direct me away from the diagnosis of lung cancer was if there was a specific tumor marker that pointed in some other direction. And so I felt that was the one test that could not be explained to my satisfaction without finding out what other people's experience had been.
Q All right. But for what reason? What was the reason that you wanted to obtain this information in about May of 1993? What use did you intend to put it to? This is about two years after Mildred Wiley is deceased, correct?
A Yes, it was. It occurs to me that there was

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some thought at that point in time that the case might be moving forward around that time and that it would be necessary to review the case in preparation for deposition. That's my recollection why the move at that time.
Q When you refer to the case moving forward, you're talking about the case that was brought by Philip Wiley in which your deposition is being taken?
A Yes, sir.
Q And are you also referring to the Worker's Compensation claim that Philip Wiley had?
A No. I really do not recall knowing about that or being involved with that.
Q Well, you knew about it because of the prior correspondence we have looked at?
A Right.
Q Attorney Joseph Young had written to you about the Worker's Compensation claim and asked you about information and to write a letter and all that by the time this memorandum, Exhibit 18, was written, correct?
A That is correct.

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Q So you were engaged in these exercises in talking to Dr. Hayes and telling Dr. Turner what your conversations were with Dr. Hayes because you thought that it would be something important to the lawsuit and the Worker's Compensation claims filed by Philip Wiley. Isn't that an accurate statement?
MR. YOUNG: I object to the form of the question. It's leading and just simply restating and misstating his testimony.
A I don't remember specifically thinking about what particular type of case that this was going to be related to, just that I was going to be needing to be available to discuss my participation in the case. And I don't remember differentiating as to what kind of case or which particular legal directive was being brought forth. I don't remember thinking about that.
Q Well, by May 25, 1993, Doctor, you had already received the letter from Attorney Joseph Young that we have looked at earlier in your deposition here, dated November 23, 1992, and then the follow-up letter, January 11, 1993. And you had already written a

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draft at least of a letter, if not a letter, that was sent to Mr. Young in response, correct? Those are all the exhibits that we have looked at up to this point in time, correct?
A Yes, sir.
Q So when you were engaging in these conversations with Dr. Hayes and Dr. Turner that are reflected in Exhibit 18, Doctor, it's a fair statement to say that you knew that there was a Worker's Compensation claim that was being pursued by Philip Wiley and that you were being asked for information about it, right?
MR. YOUNG: I object to the form of the question. It's leading. It's argumentative and it's compound.
A I do not specifically remember the nature of the case that was going forward, whether it was Workman's Compensation or what the case consisted of. I simply recall that it was likely that I was going to have to be submitting expert opinion relative to my dealing with this patient.
Q When you wrote Exhibit 8, the letter to

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Mr. Young dated January 22, 1993, which is approximately four months or so before the memorandum of May 25, 1993, you knew that that letter, Exhibit 8, was written by you to Mr. Young so that he could have something to use in connection with Philip Wiley's Worker's Compensation claim, correct?
A I have no recollection that that was the purpose of the letter.
Q Well, it says in the opening sentence in Exhibit 8, "I am in receipt of your request regarding my consultation on Mildred Wiley dated 6-3-91." Now, the only request in your file that I've been able to find is the letter dated November 23, 1992, addressed to you by Mr. Young which is Exhibit 12 in which he tells you that Philip Wiley is making a Worker's Compensation claim, correct?
A That is in the file. I do not remember specifically focusing in on that beyond, as I say, an opinion relative to whether or not I would agree with Dr. Turner's impression. I just simply do not remember. I don't recall focusing on the actual specific legal

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aspects of what was going on here.
Q But to be fair, you knew that there were some "legal aspects" involved here, right?
A I knew that there was information that was needed to go forward with some type of legal activity in this case. But I can't specifically say that I remember what it was about.
Q At this juncture?
A At that juncture.
Q All right. Focusing your attention again on Exhibit 18, Doctor, she mentions in the first paragraph in the one, two, three, four, fifth line from the bottom of the first paragraph, see that sentence that says, "Apparently there was some infiltration of pancreatic tissue"?
A Yes, sir.
Q Doctor, would you agree infiltration of pancreatic tissue may be an indicator or a suggestion that there was a pancreatic primary?
A That's not the way I would describe the pancreatic primary.
Q Now, I didn't ask you if that's the way you

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would describe it. I'm asking you whether or not infiltration of pancreatic tissue is suggestive of the presence of a pancreatic primary carcinoma?
A No. It could be primary or secondary.
Q You say it could be primary or secondary, correct?
A It's very nonspecific.
Q All right. But my question, Doctor -- well, let me rephrase the question. Would infiltration of pancreatic tissue suggest the possibility of the presence of a pancreatic primary carcinoma?
A No.
Q The next paragraph of Exhibit 18 refers to a Dr. Recometa, R-E-C-O-M-E-T-A. Did you ever have any discussions with that doctor?
A No, sir, not to my recollection.
Q Dr. Turner recites there that she is going to obtain all the copies of the mammograms from that doctor. Did you ever look at those mammograms?
A Not to my recollection.
Q The next sentence refers to a Dr. Michael Clark. Did you ever have any discussions

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with him?
A Not to my recollection.
Q Do you know him?
A No, sir.
Q Did you ever have any discussions with Dr. Turner about her conversations with Dr. Clark?
A Not to my recollection.
Q In the fifth line from the bottom of Exhibit 18 Dr. Turner states, "We are now attempting to contact the nurses who have been on that ward." The ward apparently where Mrs. Wiley worked. Did you ever contact any of those nurses?
A No, sir.
Q Did you ever have any discussions with Dr. Turner about contact with such nurses?
A Not to my recollection.
Q Do you know a Dr. Ralph F. Winkler?
A No, sir.
Q Do you recall ever having any conversations or communications of any kind with a Dr. Winkler?
A Not to my recollection.
Q If you look at Exhibits 9 and 10 with me for

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a moment, please. And if you could get in front of you also at the same time, Doctor, Exhibit 8. Exhibit 8 is a letter that's addressed to Attorney Joseph Young dated January 22, 1993, that we have already talked about. And Exhibits 9 and 10 are for want of a different term different versions of Exhibit 8, correct?
A Except that the dates are in reverse. This one came last, but they seem to be saying basically the same thing.
Q I didn't follow when you said the dates are reversed.
A I thought you were saying these had come along after this.
Q Well, Exhibit 8 is dated January 22, 1993, correct?
A Right.
Q And exhibit --
A Okay. I'm sorry.
Q Exhibits 9 and 10 are dated June 21, 1993, correct?
A Okay. I'm sorry, I've been thinking that was June all along. I'm sorry.
Q Okay.

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A June 22nd and trying to figure it.
Q All right. No problem.
A Okay. That helps.
Q And let's just focus on Exhibit 10 for a moment. In the third paragraph there is a second sentence there that says, "Indeed, I have reviewed the patient's hospital chart from Ball Memorial Hospital as well as the autopsy report and the circumstances of this case, all of which lead me to the conclusion that this is a case of bronchogenic carcinoma, the origin of which is consistent with environmental tobacco smoke exposure." Do you see that?
A Yes, sir.
Q Now that sentence does not appear in Exhibit 8; does it?
A No, sir.
Q Now Exhibit 8 -- excuse me -- Exhibits 9 and 10, as nearly as I can figure them out in comparison, there is only one change between those two letters or one difference, if you will, and that is in the first sentence of Exhibits 9 and 10, which I don't want to dwell on because I don't really think it's

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significant. But let me ask you about that sentence in the third paragraph that we just read together in Exhibit 10. "Indeed, I have reviewed the patient's hospital chart," and so forth. How was it that that sentence got added to this letter?
A Are you saying added to the January 22nd letter?
Q Yes.
A I don't know.
Q Between the time that you wrote Exhibit 8 which is dated January 22, 1993, and the dates on Exhibit 10 or the date on Exhibit 10 which is dated June 21, 1993, didn't you have conversations with Mr. Young about changes that he wanted you to make to that letter?
A Not that I recall.
Q As you sit here today, Doctor, is it your testimony that you are unable to tell me how and why the sentence that I read with you and to you in Exhibit 10 got put in Exhibit 10?
A I do not know what resulted in the change from the dictation of January 22nd to the

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dictation of June 21st.
Q That sentence says, again to repeat it, it says, "You have reviewed the patient's hospital chart from Ball Memorial as well as the autopsy report." Do you recall reviewing those documents before you wrote Exhibit 10?
A Given the discussions relative to my calling Dr. Dan Hayes, I believe that, indeed, during that time frame, I did pursue further review of the chart. I do not have any independent recollection as to when I sat down or to what extent I reviewed the chart.
Q And then you also say you reviewed "the circumstances of this case." What circumstances of this case did you review?
A I have no independent recollection of what I meant by that statement. I see it as a generic sort of statement that I've gone over everything to the best of my ability to review it and that was my conclusion.
Q Bear with me one more time here, Doctor, in preparing these. If you look at Exhibit 9 with me, the very first sentence reads, "I am in receipt of your request for

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information regarding my consultation on Mildred E. Wiley dated June 3, 1991." The very first sentence of Exhibit 10 says, "I am in receipt of your request for my consultation on Mildred E. Wiley dated June 3, 1991." There is a very slight difference between those two sentences. So this would tell you that you wrote at least two versions of this letter dated June 21, 1993, correct?
A Yes, sir.
Q And do you recall the circumstances that caused you to write those two versions?
A No, I don't.
Q Did you know that when you wrote Exhibit 9 that it was a letter that was to be used in support of Philip Wiley's claim for Worker's Compensation?
A I did not recall specifically what the letter was being used for.
Q Well, when you wrote Exhibit 9, you did send it delivered or mail it to Attorney Joseph Young, correct?
A It appears that it was sent on to Mr. Young, and I signed it.

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Q Is it the case that you don't remember today why you wrote the letter, or is it your recollection that you knew when you wrote the letter what it was to be used for but you've since forgotten? That's a rather complicated question. I'll break it down if you'd like me to.
A I don't believe that I knew the specific legal aspects of what was going on with this case. But I was asked to provide a medical opinion and so I sent it. But I don't believe that I knew it then, and I certainly don't know it now.
Q And you weren't able even to surmise why it was -- what it was to be used for, I should say, even in light of the fact that we have looked at correspondence from Mr. Young that he was eliciting from you certain information that was to be used in connection with the Worker's Compensation claim. Is that your testimony?
A My testimony is that I do not recall relating that to the letter that I sent. I don't remember reading that letter, and I don't remember relating it to that letter.

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Q Has anyone ever told you that Exhibit 9 was used to support Philip Wiley's Worker's Compensation claim?
A No, sir.
Q So when you hear that from me today in this deposition, that's the first time that anybody has ever told you that?
A To my recollection.
Q In the third paragraph of Exhibit 9 you refer to an opinion of Dr. Turner, correct?
A That is correct.
Q Where did you get any information about Dr. Turner's opinion that you relate there?
A That was dictated or written into the face sheet of the hospital chart.
Q Well, you don't refer to the hospital chart here, but it is in quotation marks. You say, "tobacco smoke exposure related to her work environment." Is that something that's in the hospital chart, you believe?
A No.
Q You put quotations around it in your letter. Do you see that? So apparently you were quoting something. My question is: What was the source of that quote; do you know?

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A I do not know. Could I see her admitting history and physical?
MR. YOUNG: I'm sorry, which one, Doctor?
A Her admitting history and physical. Dr. Turner's admitting history and physical.
Q That would be your Exhibit 27.
A Okay. I have her Exhibit 2.
MR. YOUNG: If it's the same, why don't you stick with your exhibit?
A 22.
Q It's your Exhibit 27, I believe, Doctor.
A Okay. I don't know where that quote was.
Q Well, we won't spend any more time on it now. Were you aware of the fact that iron studies for asbestos were done on Mildred Wiley's lung tissue?
A I saw Exhibit 7 when I was reviewing the chart.
MR. YOUNG: I guess I'll ask you to narrow that down when you say, when was he aware, time frame?
MR. WAGNER: Well, I can only ask one question at a time, Jim, so –
MR. YOUNG: Okay.

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MR. WAGNER: The first question is, was he aware.
Q And can I see that exhibit just a second, Doctor, to make sure I've got the same thing you're looking at.
All right. Now Exhibit 7 has some handwriting on it. Do you know whose handwriting that is?
A That's Dr. Turner's.
Q And can you read into the record what it says?
A "Joe, FYI," for your information, "do you think we should look at this further."
Q And did you have any conversations with Dr. Turner in response to her note?
A None that I recall.
Q Do you recall ever discussing with Dr. Turner the substance of that correspondence or anything to do with the iron stains?
A No, sir.
Q You just don't have any recollection of that subject at all?
A No, sir.
THE WITNESS: Can we go off the

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record for a second?
MR. WAGNER: Sure.
(A discussion was held off the record.)
(Defendants' Exhibit(s) 60 marked for identification.)
Q Have you ever seen Exhibit 60 before today, Doctor?
A Not to my recollection.
Q Do you recognize the handwriting on that document?
A No, sir.
Q Doctor, excuse me, are you still reading that document?
A No. I'll keep it separate.
Q Have you read it again? Do you recognize the handwriting at all?
A No, sir.
Q Doctor, did you attach any significance to the rapidity with which Mildred Wiley's cancer progressed from the time she presented until her death?
A Explain what you're asking. Any significance meaning?
Q Yes. I'm talking about, of course, medical

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significance in terms of diagnosing or treating her cancer or any observations that you may have professionally that would arise out of the rapid progress of her cancer from the time she presented until her death.
A By the time she presented to Ball Memorial Hospital, it was an advanced case. And so there were no surprises, I would say, in terms of how fast things developed over the three to four weeks she was at Ball Hospital.
Q Are certain kinds of cancers more aggressive than others?
A Yes, sir.
Q What are the more aggressive cancers?
A Oat cell which is small cell undifferentiated. Carcinoma of the lung is one of the more rapidly developing malignancies that we see in adults. There are some germ cell malignancies that are seen in men, testicular cancers that are aggressive. Malignant melanoma is a malignancy that can be very aggressive. The hematologic malignancies such as certain types of Non-Hodgkin's lymphoma can be very

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aggressive. Those are the ones that come to mind for solid tumors in adults.
Q Are pancreatic cancers particularly aggressive?
A I would not characterize pancreatic cancer as an aggressive tumor.
Q Doctor, having reviewed the medical records with you, is it accurate to say that you did not treat Mildred Wiley for primary lung cancer?
A That is correct.
Q Doctor, it's correct, isn't it, that during the time that you treated Mildred Wiley you never made a written diagnosis that her cancer was caused by environmental tobacco smoke?
A That is correct.
Q Now, Doctor, you are not a pharmacologist; is that correct?
A I'm not a pharmacologist.
Q Do you claim expertise in pharmacology?
A I do not claim expertise in pharmacology.
Q And you're not an epidemiologist, and you do not claim to be an expert on epidemiology; is that correct?

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A That's correct.
Q And you are not an expert on the chemistry of tobacco smoke or environmental tobacco smoke; is that correct?
A That is correct.
Q And you are not a pathologist, and you're not an expert on pathology; is that correct?
A That is correct.
Q And you are not a toxicologist, and you are not an expert on toxicology; is that correct?
A That is correct.
Q Have you ever read any of the original epidemiological studies on the subject of whether there is any relationship between environmental tobacco smoke and health?
A Original epidemiologic studies, for example? I'm not sure what you mean.
Q Well, as you sit here today, do you have an understanding that there are epidemiological studies that have looked at whether or not there is any association, statistical association, between environmental tobacco smoke and health?
A Yes, sir.

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Q My question is: Have you ever read the originals of any of those studies?
A No, sir.
Q Have you ever smoked?
A No, sir.
Q Anyone in your family smoke?
A Currently, did you say, has or --
Q Let me rephrase. Has anyone in your family ever smoked?
A Living?
Q I'm talking about your immediate family.
A My immediate family, yes.
Q Who?
A I have an 18-year-old daughter.
Q Who smokes?
A Smokes.
Q Does she smoke in your presence?
A No.
Q Do you know any doctors who smoke?
MR. YOUNG: I object, relevance.
A I have no current knowledge of medical doctors whom I'm acquainted with that smoke.
Q What are the policies at Ball Memorial Hospital with respect to smoking?
A Ball Hospital has become a smoke-free

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institution. I believe that psychiatric patients are allowed to smoke with the order of their physician.
Q They are allowed to smoke in the hospital?
A I believe that's correct.
Q And other than that exception, no smoking is allowed within the facility?
A To the best of my knowledge. I don't know if there are smoking areas allowed. I believe that employees have to smoke outside.
Q Do you know what the definition of environmental tobacco smoke is?
A My definition would be if you are in close proximity to someone who is smoking cigarettes or other forms of tobacco in a closed environment or in a close environment.
Q Do you know what the technical definition is of environmental tobacco smoke such as definitions that are used by the Environmental Protection Agency or other governmental or scientific bodies?
A No.
Q Do you know what the differences are between

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smoke that's inhaled by mainstream smoking, a smoker who smokes a cigarette, and environmental tobacco smoke that may be inhaled?
A I have some references that relate to that.
Q Are those references you've read within the last two weeks prior to your other deposition?
A Yes, sir.
Q So whatever knowledge you have about those differences you acquired from those sources within the two weeks prior to October 31, 1997?
A For the most part.
Q And they would appear in what we have previously marked for identification as -- what is it, Exhibit 2?
A Yes, sir, Exhibit 2.
Q Do you agree, Doctor, that there are reliable and respected scientists who have expressed doubts that environmental tobacco smoke has been proven to be a cause of lung cancer?
A I'm aware of the debate. I have no firsthand knowledge of what individual

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participants in that debate would state.
Q When you say you are aware of the debate, do you mean that you are aware that there are reliable and respected scientists who may be on both sides of the debate?
MR. YOUNG: I object. That's leading and argumentative.
A I have not personally read of those types of individuals or their statements as to the argument against it. My literature review included three medical oncology texts, all of which discussed the reality of the risk of environmental tobacco smoke.
MR. YOUNG: Dick, could I ask your indulgence for a restroom break?
MR. WAGNER: Can I ask your indulgence just to ask one more question?
MR. YOUNG: Sure.
Q Just to hurry this along, can I see Exhibit 2 here just for a second? If you'll look at the third page of your Exhibit 2, Doctor, you see the second entry from the bottom there, it starts out, "The effect of passive smoking"?
A Yes, sir.

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Q And there is a discussion there about passive smoking. And would you read the last sentence of that entry that you have written down in your handwriting?
A "However to date the evidence supporting the effects of passive smoking remains rather circumstantial."
Q And that is a sentence that you copied out of one of the treatises that you have told me earlier you would deem to be authoritative, correct?
A Yes, sir.
MR. WAGNER: Let's take a break.
(A brief recess was taken.)
BY MR. WAGNER:
Q Doctor, would you look at Exhibit 18 with me for a moment, please?
A Yes, sir.
Q I think I put it right there in front of you. It has some parenthetical markings in the last paragraph, I believe in the original in red, correct?
A Yes, sir.
Q Are those yours?
A I do not recall doing that, but I was using

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a red pen to highlight various parts of the record. And if it was done, it would have been done in preparation -- I mean, if I did it, it was immediately prior to my deposition which began two weeks ago. I don't remember specifically.
Q You don't remember one way or the other whether those are your markings; is that correct?
A That's correct.
Q Could they be anybody else's? That is to say, would anyone else have had access to your file to make those markings?
A What I'm saying is I don't remember if when I first saw this letter whether they were there, but I have no knowledge as to whether anyone else would have had access or not.
Q Okay.
A These were the ones that came from my chart, my separate folder.
Q Exhibit 18 is?
A Yes, sir.
Q That is one of the documents that you produced for us?
A Yes.

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MR. YOUNG: I think for the record it ought to be clear it might be a distinction of what is his file, quote, unquote, and what was produced in response to the subpoena for the deposition. And I'm not sure those terms should be interchangeable.
MR. WAGNER: I don't want to confuse you either.
Q Exhibit 18, Doctor, is one of the documents that you brought to us at the beginning of the deposition on October 31st, correct?
A Yes, sir.
Q And that was a document that you had in your file that you brought here, correct?
A In a separate folder, yes.
Q Do you know of any reason why those parentheticals would have been put around that sentence as you sit here today?
A It was information relative to passive smoke exposure that, to my knowledge, I had not previously seen.
Q And you're unsure whether those parentheticals are yours or not?
A That is correct.

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Q Who is TJG whose initials appear at the bottom opposite Dr. Turner's initials?
A That would be one of our transcriptionists.
Q I mean, do you know her name?
A Tony Graham, I believe.
Q Is she still in the employ of your medical group?
A Yes, sir.
Q Referring you to Exhibit 8, can you tell us the name of the person who typed that document for you by looking at the initials in the lower left-hand corner?
A I believe it's SAW, and that does not ring any point of recollection.
Q You're unable to remember the name of that person?
A No, sir.
Q Okay. Let me refer you to Exhibit 9 which shows the initials, DH, as the person who transcribed the letter. Do you know --
A Deloris Hedges.
Q Is she still with you?
A Yes, sir.
Q And then Exhibit -- can I see that for a second?

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A Yes.
Q Can you name any substances that are believed to be carcinogens that are in environmental tobacco smoke?
A Very generically, polycyclic hydrocarbons and aromatic amines appear. Biochemically I don't know what they are. I have several listed in one of the references, but they didn't relate to anything I'm familiar with biochemically.
Q Can you name any specific constituent of environmental tobacco smoke that has been scientifically proven to be the cause of lung cancer?
A Are you asking about a specific constituent?
Q Yes, sir, a specific constituent in ETS that has been scientifically proven to be the cause of lung cancer.
A I read where the nitrosamines are present in ETS in excess concentration compared to mainstream, and that's a known carcinogen.
Q Are you aware of any scientific literature which exists that proves that that substance is the cause of lung cancer?
A Just by reference that I've brought to the

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deposition and they say that there are known carcinogens. One of the references lists --
Q You're referring to your Exhibit 2, Doctor?
A In Exhibit 2 they talk about carcinogens.
Q What page are you on, Doctor?
A Page 155.
Q I'm sorry, what page of Exhibit 2 are you on?
A Page 1.
Q Page 1, you're referring to COP 155?
A Yes, sir.
Q Where you've written 3,000 chemicals in cigarette smoke. More than 30 are carcinogenic in animals; is that right?
A Yes, sir.
Q That doesn't mention nitrosamines; does it?
A I would have to look at the reference to see if that's among that list.
Q Would it be fair, Doctor, to say that whatever you would know about that subject, you would have to go back and look at your reference that's reflected there in your notes?
A Yes, sir.
Q Would you agree, Doctor, that there is no

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test or procedure that could be used to examine a malignant tumor and determine exactly what caused that cancer?
A Are you specifically asking about cancer in general or cancer as it relates to ETS?
Q I think the question speaks for itself. Let me just repeat it. Would you agree, Doctor, that there is no test or procedure that could be used to examine a malignant tumor and determine exactly what caused that cancer?
A I believe there are some that can be used. There is a type of lymphoma that's associated with the Epstein-Barr virus, and that can be tested. So that's one that comes to mind. So I think the answer to your question would be, no, that I don't agree that there is no test.
Q All right. Do you know, as you sit here today, whether or not there are any such tests other than the one you just described for me that relates to the Epstein-Barr virus?
A Nasopharyngeal carcinoma and Non-Hodgkin's lymphoma of the Burkitt's type are the two

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that are associated with Epstein-Barr virus.
Q All of those that you have just mentioned to me are associated with Epstein-Barr virus?
A Yes, sir.
Q Any other than that?
A Those are the two that come to mind.
Q Do you agree, Doctor, that are there carcinogens in the food we eat and the air we breathe?
A Yes.
Q Can you name any of those for us?
A There are certain types of cancer that are more likely to occur, for example, with a high intake of fat, and so that could be considered a carcinogen. There are certain types that are associated with increased intake of alcohol. Those are two that come to mind as far as ingestants.
Q Is there aflatoxin in peanut butter and is aflatoxin a carcinogen?
A Aflatoxin is a carcinogen.
Q Does it exist in peanut butter?
A I'm not familiar with it being in peanut butter. I think of it being in certain types of beans, but I don't know.

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Q Do Cola drinks contain formaldehyde?
A Not that I'm aware.
Q Are you aware that there is benzene in strawberries?
A No, sir.
Q Is chloroform a carcinogen?
A I'm not sure if chloroform is -- in reading about chloroethyl esters if chloroform would be one of those or not.
Q Would you agree, Doctor, that having stated that there are carcinogens in foods we eat, air we breathe, that they don't make us ill because they are present in small amounts?
A I don't think you can say that specifically. I think you have to look at whether there is host vulnerability and whether the host is predisposed to perhaps an exposure that could trigger an event. I don't know specifically that you can say universally that it's strictly a matter of concentration. I would not say that.
Q There are threshold levels of exposure to substances that might be harmful, but they aren't harmful because the exposure is small and produce no increased risk; isn't that

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so?
A Time of exposure and amount of exposure enters into the risk of carcinogens.
Q One of the things that you have to consider when you're assessing risk with respect to a particular agent and health defects is the amount and duration of exposure. Would you agree with that?
A I would agree.
Q What amount of environmental tobacco smoke has to be inhaled in order to cause lung cancer?
A I don't have a specific parts per million or any information on that threshold.
Q So you don't know the answer to that question, correct?
A That's correct.
Q Do you agree that the Environmental Protection Agency and the Surgeon General have said that radon is a second leading cause of lung cancer?
A I have read that. I couldn't tell you who stated it first. It's in some of my texts that it's a leading cause of lung cancer.
Q Okay. So regardless of who said it first,

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you would agree that the Surgeon General and the Environmental Protection Agency have said that radon is the second leading cause of lung cancer, correct?
A I don't know who said it. I've read it, and so I believe that radon is one of the risks which I've written down for environmental exposure for lung cancer.
Q Would you look at your Exhibit 3?
A Yes, sir.
Q And if you look at page 326 of Exhibit 3, there is a table set out there?
A Yes, sir.
Q And do you see the category ionizing radiation?
A Yes, sir.
Q And over on the right side in the last four lines that relate to that particular subject, it says, "Regulatory agencies generally assuming linear nonthreshold dose-response curve, indoor radon accounts for more than 50 percent of all radiation exposure received by general population and based on extrapolations from high-dose miner studies may cause 5,000 to 20,000 lung

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cancer deaths per year in the United States." Correct?
A Yes, sir.
Q And that's set out in an authoritative text?
A Yes, sir.
Q And, Doctor, it's a fact, isn't it, that you were unable to rule out the possibility that Mildred Wiley had lung cancer caused by her inhalation of radon?
A I don't recall if we have information on radon in the environment.
Q Do you know all the places where Mildred Wiley lived?
A No, sir.
Q Do you know all the places where Mildred Wiley worked?
A No, sir.
Q It's a fact, isn't it, Doctor, that you have no knowledge or information as you sit here today about Mildred Wiley's potential exposure to radon; isn't that correct?
A That is correct.
Q And it's also correct then, Doctor, as a matter of logic and fairness, that you are unable to rule out the possibility that

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Mildred Wiley had lung cancer caused by her inhalation of radon?
MR. YOUNG: I object to the form of the question with reference to inhalation of radon?
A I have no information relative to radon exposure.
Q So you were unable to rule it out; isn't that correct, Doctor?
A I could not rule it out.
Q Pardon me?
A I cannot rule it out.
Q Doctor, isn't it correct that you have never made any measurement or quantification of environmental tobacco smoke to which Mildred Wiley was exposed?
A That is correct.
Q In fact, you have never measured environmental tobacco smoke anywhere in any environment; isn't that correct?
A That is correct.
Q Have you ever been to the Veteran's Administration Hospital where Mildred Wiley worked?
A That's the Marion VA Hospital in Marion,

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Indiana?
Q That's what you believe to be the place where she worked?
A I have been in the Marion VA Hospital.
Q When was the last time you were in that hospital?
A I would say in the range of three years ago.
Q Were you ever in Building 16 of that hospital?
A I don't know where I was. I was visiting a patient there.
Q As you sit here today, to your knowledge, have you ever been in Building 16 of that Veteran's Administration Hospital?
A Not to my knowledge.
Q Subsequent to Mildred Wiley's death, have you ever talked to any of her family members?
A No, sir.
Q Do you know what hours Mildred Wiley worked at the Veteran's Administration Hospital?
A No, sir.
Q Do you know what days she worked at that hospital?
A No, sir.

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Q Do you know the size of Building 16 that she worked in?
A No, sir.
Q Do you know how many rooms there were in that building?
A No, sir.
Q Do you know where smoking was allowed and not allowed in that building?
A No, sir.
Q If you had a patient, Doctor, that came to you and said that she was breathing something at work that was injuring her health, what additional information would you as a physician want to have before you made a diagnosis and advised a course of treatment?
MR. YOUNG: I'll object. That's vague and an improper hypothetical.
A If I had such a patient, I would request information on what the material was that they were being exposed to.
Q You would want to know a lot about what the agent was that she was purportedly breathing, right?
A Yes, sir.

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Q And you would want to know how much she was breathing, correct?
A I think I would want to learn what the material was and find out all I could about it, send her to somebody that knew more about that kind of thing than I do.
Q And you would want to know how much exposure she had to that particular agent, would you not, whether it was for five seconds or five days or five years? That would be important information; would it not?
A That would be part of the environmental history.
Q And that would be important to you in diagnosing and treating the patient; would it not? In other words, you would want to know that information in the first instance as to whether or not you as a physician could say that the agent that she was telling you about could be a causative factor of her health complaints; would you not?
A That would be information I would need.
Q Do you know what kind ventilation system they had at the VA Hospital where Mildred

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Wiley worked?
A No, sir.
Q Do you know whether or not Mildred Wiley had exposures in her employment outside of the Veteran's Administration Hospital, any other jobs that she had, to such things as X-rays and chemicals and chemotherapy agents?
A No, sir.
Q Have you ever treated any other patient other than Mildred Wiley who you believe had lung cancer caused by environmental tobacco smoke?
A I don't recall.
Q If you did, you can't recall it, correct?
A If I did, I do not recall the patient.
Q Are you familiar with the term, poorly differentiated carcinoma, of unknown primary site?
A Yes, sir.
Q What is that?
A It's a diagnosis that appears under the microscope as an epithelial malignancy which means it's a carcinoma. And its differentiation is such that it's not obvious what tissue it comes from, and it is

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not known where it originated.
Q When you get a differential diagnosis with respect to Mildred Wiley's case, did you consider fully differentiated carcinoma of unknown primary site?
A The original biopsy of the chest wall which was the first biopsy that was returned was a poorly differentiated carcinoma.
Q So, did you consider that diagnosis, that is to say the diagnosis of poorly differentiated carcinoma of unknown primary site?
A No, because we had not at that point looked for primary sites of origin. That would be the diagnosis you would entertain after you had looked for other sites of origin. And that was just the first investigation that had taken place in that case.
Q Let me ask the question this way, Doctor, sort of encapsulate this. During the time you were treating Mildred Wiley or any time since you treated Mildred Wiley in performing a differential diagnosis with respect to her case, have you ever considered poorly differentiated carcinoma

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of unknown primary site?
A No, sir.
Q Looking back over her medical history, Doctor, isn't it a fact that the pathology reports and other history that you obtained with respect to Mildred Wiley and other information you received about her case fit that diagnosis?
A No, sir.
Q Why not?
A It was not a poorly differentiated carcinoma. It was an adenocarcinoma as substantiated by a fine needle aspiration of the lung on 6-12 by the autopsy results.
Q Well, there was a consensus among the pathologists who looked at the pathological specimens on any occasion that it was clearly an adenocarcinoma; isn't that correct?
A Prior to death?
Q That's correct.
A Prior to death the pathology report that was submitted says that it's an adenocarcinoma. In the discussion it was mentioned that there was some debate among the

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pathologists.
Q And the debate included a poorly differentiated carcinoma; did it not?
A What is the number?
Q Tell me what you're looking for, and I'll see you if I can help.
A Of the fine needle aspiration on the lung on 6-12. Exhibit 51.
Q Exhibit 51 in the comment section, Doctor, tells us that, "Dr. Sandquist and myself favor a diagnosis of adenocarcinoma. Dr. Brown favors the diagnosis of poorly differentiated carcinoma," correct?
A Yes, sir.
Q So there wasn't a consensus among the pathologists. At that time one of them believed it was poorly differentiated carcinoma, correct?
A One pathologist favored poorly differentiated carcinoma.
Q And would you look at Exhibit 34? That's another pathologist report, correct?
A That was the chest wall biopsy that I talked about.
Q And what was the pathological diagnosis

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there?
A Poorly differentiated carcinoma.
Q Well, Doctor, having reviewed those pathological reports, I ask you again, wasn't it something that should have been included in the differential diagnosis that Mildred Wiley presented with a case of poorly differentiated carcinoma of unknown primary site?
A No, sir.
Q Was her clinical course consistent with poorly differentiated carcinoma of unknown primary site?
A No.
Q Let me read to you something, Doctor, that is in DeVita, page 2431. This is in relation to poorly differentiated carcinoma of unknown primary site. "Patients with poorly differentiated carcinoma often give a history of the rapid progression of symptoms, often fewer than 30 days and have objective evidence of rapid tumor growth. More importantly the location of metastasis differs in the predominant sites involved and are frequently lymph nodes, mediastinum,

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retroperitoneum occurring much more commonly than in well-differentiated adenocarcinoma."
Now, doesn't that fit Mildred Wiley's case?
A If we didn't have the site of primary origin, it would.
Q What do you believe to be the site of the primary origin?
A We have a biopsy of the lung.
Q Well, the biopsy of the lung simply shows it's adenocarcinoma. Biopsy of the lung doesn't show that it was taken by fine needle aspiration, that it was a primary to the lung; does it, Doctor?
MR. YOUNG: I object. That's argumentative.
A You said that the fine needle aspiration lung diagnosed adenocarcinoma?
Q Let me repeat it. When you talk about the diagnosis of adenocarcinoma from biopsy, are you referring to the fine needle biopsy?
A The fine needle biopsy of the lung tumor.
Q That's what you're referring to?
A Right.
Q All right. That fine needle biopsy and the pathological report about it doesn't show

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that it was a primary adenocarcinoma of the lung; isn't that correct?
A That biopsy in and of itself does not prove the primary origin, but it rules out a poorly differentiated adenocarcinoma.
Q At that point?
A An adenocarcinoma is not a poorly differentiated carcinoma.
Q The other pathological report that we looked at, though, did refer to poorly differentiated carcinoma; isn't that correct?
A The original chest wall biopsy.
Q And at least one of the other pathologists that we looked at disagreed and thought that it was a poorly differentiated carcinoma, correct?
A That's correct.
Q So you discount those pathological reports entirely?
MR. YOUNG: I object. I think that over and misstates his testimony. And I think it's argumentative. It's an improper question.
A I would not say I discount those reports

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entirely. The sequence was, the initial biopsy was a chest wall which is not associated with any organ. Subsequently then fine needle aspirate of the lung was done which was reported out the final designation on the pathology report was adenocarcinoma. So, in my opinion, that rules out a poorly differentiated carcinoma. And in my opinion the carcinoma was not of unknown origin. So I cannot make a diagnosis of poorly differentiated carcinoma of unknown origin.
Q Could you have made a diagnosis of poorly differentiated carcinoma of unknown origin when you had the pathological reports that stated that what they were looking at was undifferentiated carcinoma?
MR. YOUNG: I object. I think that question assumes matters that are not in evidence. They are not accurate.
A Would you ask that question again?
MR. WAGNER: Read it back.
(The requested material was read by the reporter.)
MR. YOUNG: Same objection.
A There is no report in this chart of

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undifferentiated carcinoma. You're asking a hypothetical question?
Q Let me rephrase, poorly differentiated carcinoma?
A Thank you. If that had been the only site of cancer that the patient had and you did a biopsy of the chest wall and it was read out as a poorly differentiated carcinoma and that was the only site that could relate to an organ, you could entertain the diagnosis of poorly differentiated carcinoma of unknown origin.
Q Doctor, in your practice is it the case that most of the patients that you see already have a diagnosis that they have cancer?
A Yes. When we see a patient for medical oncology consultation, the diagnosis would usually have been established or suspected by the time we see the patient.
Q And if it's established, it's established by a pathologist who examines tissue?
A That's one means.
Q Well, what are the other means?
A You can diagnose malignancy on a bone marrow aspirate biopsy. That would not

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specifically be a pathologic diagnosis.
Q But typically diagnoses of patients who have cancer are made by pathologists who examine tissue under a microscope, correct?
A Yes, sir.
Q Would you agree, Doctor, that no one knows the exact mechanism by which a normal cell becomes cancerous?
A I don't know the mechanism.
Q Would you agree, Doctor, that cancer is a multifactorial disease?
A In some cases.
Q And that means it has many causes?
A In some cases it's multifactorial, not in all cases.
Q Causes of cancer can include diet, high-fat diet?
A There is an increased risk of certain types of cancer --
Q Radon?
A -- in patients that have a high-fat diet. There is unequivocal evidence of a diagnosis of a lung cancer associated with radon.
Q Asbestos?
A Asbestos.

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Q Viruses?
MR. YOUNG: I'm sorry?
Q Viruses?
A That is correct.
Q Antineoplastic drugs are associated with cancer?
A That is correct.
Q Paints and solvents?
A Yes, sir.
Q Formaldehyde?
A Yes, sir.
Q Cytostatic drugs are associated with cancer?
A I assume that's talking about the cancer chemotherapy drugs.
Q Yes. Can they be a cause of cancer?
A Yes, sir.
Q Neoplastic drugs and cytostatic drugs are used in hospitals?
A Well, they are used for cancer chemotherapy.
Q In hospitals where chemotherapy may be administered?
A Are you asking of environmental exposure to those or are you talking about patient exposure?
Q Let me ask a little different question.

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Cytostatic drugs and neoplastic drugs are drugs that are administered to patients, correct?
A Right.
Q Patients who have cancer?
A Yes, sir.
Q And they themselves can be associated with a risk of causing cancer, correct?
A Later on.
Q All right.
A Someone is treated for a cancer with a, what we call, a cytostatic drug or antineoplastic drug which is chemotherapy. And, yes, there are certain risks if you survive that malignancy that you can develop other malignancies later on.
Q And my next question is: The administration of those drugs takes place in hospitals, correct?
A Outpatient probably more now than hospitals.
Q All right. Well in the outpatient section of a hospital, correct?
A We give them here.
Q All right.
A A lot of outpatient.

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Q Can it take place also in doctors' offices?
A Yes, sir.
Q All right. Would you agree, Doctor, that nonsmokers can get lung cancer?
A Yes, sir.
Q Do you agree, Doctor, that nonsmokers can get adenocarcinoma of the lung?
A Yes, sir.
Q Do you know, Doctor, that only about ten percent of smokers get cancer?
A Ten to 15 percent of smokers with lung cancer.
Q Doctor, I want you to assume there was no history or any information ever obtained that Mildred Wiley was exposed to environmental tobacco smoke. What are the other possible causes of her cancer?
MR. YOUNG: Well, I'll object. That calls for speculation and asks him to assume evidence or facts that are not true and not in evidence.
MR. WAGNER: That's the whole purpose of a hypothetical.
MR. YOUNG: It's an improper hypothetical.

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Q Go ahead, Doctor. You can answer.
A You're saying if you had a case like Mildred Wiley and there was no environmental exposure that could be elicited, what would be the cause, or are you saying what would the other --
Q If I can interrupt you just for a moment. Let me repeat the question.
A Okay.
Q I want you to assume that there was no history ever taken or any information given that Mildred Wiley was ever exposed to environmental tobacco smoke. Under that assumption, what are the other possible causes of her cancer?
MR. YOUNG: Same objection.
A We have talked about asbestos, radon. You brought up radiation. The pattern and distribution of this particular malignancy then asks for some irritant to the tracheobronchial tree. And on that basis you would make an effort to find out what those irritants could have been.
Q Does that complete your answer?
A I believe so.

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Q Doctor, isn't it a fact that adenocarcinoma of the lung are almost always peripheral tumors?
A They are more commonly peripheral than central.
Q Prior to the time you began treating Mildred Wiley, had you ever treated any patient who you believed presented with an endobronchial adenocarcinoma which you diagnosed as originating in the bronchus?
A I have no recollection of the specific case. It is not unusual to have that happen. It's not the most common presentation.
Q It's a fact, Doctor, that you had never seen it in any patient that you can remember before you began treating Mildred Wiley?
A I cannot give you the name of the patient that I had seen prior to that who had the same diagnosis. I think it's unlikely that I didn't. I cannot give you the name of the patient before or after.
Q You agree, Doctor, with this statement, that once the disease is suspected, a simple and effective method of obtaining positive diagnosis of lung cancer is sputum cytology?

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A No.
Q Would you agree with this statement, Doctor; that with three sputum samples up to 80 percent of central tumors can be diagnosed. The yield is much smaller for peripheral tumors dropping to less than 20 for peripheral tumors less than 3.0 centimeters in diameter?
A I can't say that I have firsthand information on those percentages. Clearly a central tumor with endobronchial origin such as this patient had, had the bronchus intermedius not been off, completely closed off, I think one would have had potential to diagnose with sputum.
Q You understand I'm asking these questions in general, not in particular with respect to Mildred Wiley's case. And you would disagree with the first statement that I read?
A I can't agree or disagree with the percentages. I agree that you're more likely to be able to diagnose an adenocarcinoma lung or any type of lung cancer with sputum cytology when there is

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central rather than peripheral origin.
Q Would you agree with this statement, Doctor, the diagnostic yield of fiberoptic bronchoscopy with cytology brushings and biopsy for histology when a visible lesion is identified is higher than 90 percent?
A I don't have any reason to agree or disagree. I don't know.
Q Do you agree, Doctor, in the United States in 1995 pancreatic cancer was the fifth leading cause of adult deaths from cancer?
A What year?
Q 1995 in the United States pancreatic cancer was the fifth leading cause of adult deaths from cancer?
A I cannot agree or disagree.
Q Do you have any reason to think that statement is wrong?
A It seems high, but I have no -- I have no recollection of that data of 1995.
Q Would you agrees with this statement, Doctor, that because of the difficulties in diagnosis the aggressiveness of pancreatic cancer and the lack of effective systemic therapies, only one percent to four percent

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of patients with adenocarcinoma of the pancreas will be alive five years after diagnosis?
A I agree.
Q Would you agree, Doctor, that there is a tendency for many malignancies to preferentially metastasize to the lung?
A That's true.
Q Let me read this statement to you, Doctor, and see if you agree with this.
Endobronchial and peribronchial metastases are much less subtle radiograph and appear as areas of lobar collapse, segmental atelectasis, pneumonitis and post obstructive pneumonia.
A Would you read that one more time?
Q Endobronchial and peribronchial metastases are much less subtle radiograph and appear as areas of lobar collapse, segmental atelectasis, pneumonitis and post obstructive pneumonia?
A That's typical of a description of an endobronchial lesion, whether it's primary or secondary.
Q So you would agree with that statement?

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A True.
Q Let me read another statement to you.
Endobronchial metastases are seen in approximately 28 percent of patients and are most frequently associated with cancer to the breast, colon, kidney and pancreas.
Would you agree with that statement, Doctor?
A Most commonly associated with breast, kidney and pancreas?
Q And colon.
A My experience includes renal cell carcinoma or kidney cancer and colorectal as being most common, not breast and pancreatic.
Q All right. You say based on your experience and of course --
A And my general reading. When I think of endobronchial, you think of endobronchial metastatic disease. I don't think of breast and I don't think pancreas. I think of renal cell carcinoma. I think of colorectal. I think of melanoma.
Q Do you have any reason to believe that that statement I just read to you is untrue?
MR. YOUNG: At this time I think I would like to interpose an objection to

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reading statements out of documents or articles or treatises out of context and asking him to agrees or disagree with those articles, the witness not having had the opportunity to review those articles, read them in their full context. I think it's inappropriate.
MR. OHLEMEYER: Counsel, I think your objection is inappropriate. I think now that you've coached the witness, I think you ought to let Mr. Wagner ask his questions the way he would like to ask them. But that's not a proper objection. If you have an objection to the form of the question, you make it as to form and move on.
MR. YOUNG: Now, wait a minute. Try not to interrupt me this time. I think that's an absolutely appropriate objection and it's not coaching anybody anything. And my objection is to reading materials out of context out of documents that the witness doesn't have -- hasn't had the opportunity to see. That doesn't coach him in any respect.

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MR. WAGNER: You made your objection.
Q Now, Doctor, can you answer the question?
A Would you read it again?
Q Sure. Endobronchial metastases -- and by the way, Doctor, when we talk about endobronchial metastases, what are we talking about?
A Spread of the malignancy from another site to the bronchial tube.
Q Endobronchial metastases are seen in approximately 28 percent of patients and are most frequently associated with cancers of the breast, colon, kidney and pancreas. And let me ask this question, Doctor, do you have any reason to think that that statement is wrong?
MR. YOUNG: I reiterate the same objection.
A I cannot agree with that statement. I don't think 28 percent of patients get endobronchial metastasis. Is it a pathology relative to autopsy? What are the circumstances?
Q Okay. So you disagree with that statement?

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A I disagree.
Q You think that statement is wrong?
A I think --
Q I'm sorry, go ahead.
A I think those are not the types of tumors that I have read about or have found to be associated within the bronchial metastatic disease.
Q Can you cite me to any literature which would support your statement that that statement is wrong?
A My general reading and experience.
Q You can't give me an author and a title?
A No, sir.
Q And is part of the basis for your disagreement with that statement, your own personal experience?
A Own personal experience and I would want to know the basis of their findings here, what group of patients. It's not fair to me.
Q You agree, Doctor, don't you, that what is written in the medical literature and in medical textbooks is based upon things that may -- and information that is much broader and more general than your own personal

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experiences?
A It may be.
Q And that your personal experiences with patients may not always be consistent with what is written in medical literature, correct?
A That may be.
Q Doctor, is there an association between high levels of coffee consumption and pancreatic cancer?
A I've seen it written both ways, and I don't have any opinion as to whether that's true or not.
Q You would agree with me that there is some literature that suggests that there may be such an association?
A That has appeared, yes.
Q Would you agree with this statement, Doctor, in North America adenocarcinoma is the most frequent tumor counting for 40 percent of all cases of lung cancer?
MR. YOUNG: Excuse me, just so I don't keep interrupting you --
MR. WAGNER: You can have a continuing objection to this form of

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questions. Is that what you're asking?
MR. YOUNG: Yes, sir.
MR. WAGNER: You got it.
A Would you read that again?
Q In North America adenocarcinoma is the most frequent tumor accounting for 40 percent of all cases of lung cancer?
A That is correct.
Q Would you agree, Doctor, with this statement, most of these tumors are peripheral in origin arising from alveolar surface, epithelium or bronchial mucosal glands. They can also arise as peripheral scar tumors?
A That is correct.
Q Would you agree, Doctor, that breast cancer is the tumor most often associated with metastatic bone disease?
A It's certainly commonly associated along with lung cancers being the two more common. I can't give you percentages, one versus the other.
Q Do you agree, Doctor, that primary lung cancer seldom metastasizes to the breast?
A I agree.

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Q Do you agree that primary breast cancer frequently metastasizes from breast to lung?
A True.
Q Would you agree, Doctor, that physical examinations of the breast and mammograms can fail to find small tumors present in the breast?
A That's true.
Q Is fatty diet a known risk factor for breast cancer?
A There is some evidence that increased intake of certain types of fats is associated with a higher risk of breast cancer.
Q Are high levels of coffee drinking associated with an increased risk in breast cancer?
A I don't know.
Q Is ionized radiation associated with increased risk in breast cancer?
A Are you talking about radiation to the breast?
Q I'm talking about whether or not -- this is a general question. Is ionized radiation a risk factor associated with an increased incidence of breast cancer?

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A I don't know.
Q Would you agree, Doctor, that the two organs from which cancers most commonly metastasize to the lung are the breast and the pancreas.
MR. YOUNG: I'll object. That's been asked and answered multiple times.
A Would you read that again?
Q Sure. Would you agree, Doctor, that the two organs from which cancers most commonly metastasize to the lung are the breast and pancreas?
MR. YOUNG: Same objection.
A I have no basis to agree or disagree.
Q Would you agree, Doctor, if a patient has an adenocarcinoma primary to one lung, the organ to which that cancer will most commonly metastasize is the other lung?
A I have no basis to agree or disagree.
Q Would you agree, Doctor, that only a small percentage of adenocarcinomas metastasize to the pancreas?
A I have no basis to agree or disagree.
Q Would you agree that about 50 percent of women who develop breast cancer have no identifiable risk factors other than age and

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being female?
A Those are two risk factors for breast cancer.
Q I asked a little different question. Do you agree, Doctor, that about 50 percent of women who develop breast cancer have no identifiable risk factors other than being -- other than age and being female?
A I have no reason to agree or disagree.
Q Are you familiar with the statistics that one out of every eight women develop breast cancer?
A Yes, sir.
Q Do you know how many nonsmoking women develop lung cancer?
MR. YOUNG: Lung cancer?
MR. WAGNER: Yes.
A No, sir.
Q Doctor, when you have a patient like Mildred Wiley who presents with multiple sites of cancer, cancer in many organs and bones throughout her body, isn't it a fact that it's very difficult to determine the primary site of the cancer?
A It can be difficult.

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Q In your prior deposition, Doctor, you said that Mildred Wiley was not a candidate for actual systemic chemotherapy. Do you recall that?
A Yes, sir.
Q Why was that so?
A Well, as has been discussed, her course was one of rapid downhill deterioration. She had widespread disease. In 1991 the point of actual fact we were not treating for the most part patients with primary lung cancer with systemic chemotherapy because we did not have good regimen. And the ones that we did have were quite toxic, and so patients that were being treated in the early 1990s were usually in better condition, had to have a certain quality of life and criteria that she would not have met to be treated for systemic chemotherapy for lung cancer, and I believe you could say for most kinds of cancer that were that far advanced.
Q All right. Let me ask you another question here, Doctor. Do you agree that an endobronchial metastases from an adenocarcinoma of the breast would be more

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likely than a primary endobronchial adenocarcinoma of the lung?
A No, sir.
Q Can you cite me to any basis for your disagreement?
A As I say, my experience and my general information relative to these diagnoses I did not see breast cancer as being the kind of cancer that commonly goes to the lungs and causes the kind of clinical picture that hers did. And I think in one of the -- in the CDC bulletin there are two reports that suggest that indeed adenocarcinoma of the lung is relatively more common as the type of cancer that's seen with ETS. And so I think that is a more likely possibility in metastatic breast cancer.
Q With all due respect, Doctor, I don't think you answered the question I asked, and it may be because we are not communicating here. I wasn't asking you about Mildred Wiley's particular case, and I wasn't asking you about adenocarcinoma in general.
My question was whether or not you would agree that endobronchial metastases

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from an adenocarcinoma of the breast would be more likely than a primary endobronchial adenocarcinoma of the lung?
A I disagree.
Q You would agree, would you not, Doctor, the primary pancreatic cancers commonly metastasize to the lung?
A That's correct.
Q Would you agree, Doctor, the primary pancreatic adenocarcinomas can metastasize to the endobronchial regions of the lung?
A As I said earlier, it's not the type I'm familiar with and have seen, nor have I read about it.
Q So you don't know one way or the other?
A I disagree with that statement, that it commonly is a bronchial metastatic source.
Q Are you familiar with a Dr. Cagle, C-A-G-L-E?
A How might I be familiar with him?
Q In connection with your work in this case subsequent to the time that Mildred Wiley passed away?
A Is he a doctor on staff at Ball Hospital?
Q No. If the name is not familiar to you, you

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can simply tell me.
A Okay. That's not familiar to me.
Q Do chest wall lesions commonly occur along with breast cancer?
A Are you talking about metastatic disease from the breast or are you talking about --
Q Yes.
A Yes, sir.
Q And would the lesion that was excised from Mildred Wiley's left chest wall be consistent with that statement, that is the statement that metastatic chest wall lesions commonly occur with breast cancer?
A You're asking if someone with breast cancer could have a chest --
Q It's a bad question, Doctor. Let me withdraw it.
The chest wall lesion that was excised from Mildred Wiley's left chest wall, do you recall that?
A Yes, sir. Yes, sir.
Q Would that be a lesion of the type that would commonly occur with breast cancer?
A It could occur in that location.
Q So the answer to my question is yes?

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A Yes, sir.
Q Does primary kidney cancer metastasize to the lung?
A Yes, sir.
Q To the bone?
A Yes, sir.
Q To adrenal glands?
A I don't know.
Q You don't know about adrenal glands?
A I don't know how often it goes to adrenal glands.
Q Can it? Not how often, but can it?
A I don't remember seeing it from the adrenal glands.
Q Doctor, it's a fact, isn't it, that tumors in the periphery of the lung can grow towards the bronchus and compress the bronchus?
A It would be unusual for tumors at the periphery of the lung, and we say in the outer half of the lung, to be able to encroach on the central airway.
Q Well, it depends upon where they are situated and where they are growing and the amount of the growth; wouldn't that be

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correct?
A That would be correct, but it would be unusual for a peripheral lesion to encroach on the central airway.
Q Can a tumor in the hilar lymph nodes grow into or compress the bronchus?
A Yes, sir.
Q Isn't it possible, Doctor, that when Dr. Turner did the bronchoscopy of Mildred Wiley that the bronchial airways were compressed and closed or partially closed by pressure extrinsic to the bronchial airways?
A Not by her description.
Q And in particular what was it about her description that would exclude that possibility?
(A brief recess was taken.)
(The requested material was read by the reporter.)
Q Doctor, before you answer, which exhibit are you looking at because there are two bronchoscopy reports?
A Exhibit 41.
Q Okay. Sir, go ahead and answer.
A Exhibit No. 41, it talks about the area of the bronchus intermedius. There was total

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occlusion of the airway with tumor and mucosal edema. And to me that means an intrinsic tumor or extrinsic tumor. You would describe that extrinsic to the bronchus, extrinsic to the bronchus. And she described the primary neoplastic process right main stem with total occlusion of the bronchus intermedius and obstruction of the middle and lower lobe segments. That describes for me an endobronchial lesion, not an extrinsic lesion.

Q You and I have agreed before, haven't we, Doctor, that you can't tell by looking at the bronchoscopy report how far the bronchoscope was into the bronchial tubes?

MR. YOUNG: I object to that attempt to restate his testimony. It's been asked and answered.

A As I read it, she got as far as the bronchus intermedius and could go no further.

Q And mucosal edema is not a malignant tumor, is it, Doctor?

A No, no, sir.

Q And none of the bronchial washings, brushings or biopsies obtained by Dr. Turner

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with the bronchoscope were positive for the presence of any malignancy; isn't that correct?

A That's correct.

Q So, Doctor, isn't it correct that what she described in Exhibit 41 that she was looking through the bronchoscope was not a malignancy?

A No, sir.

Q And how is it, Doctor, you can discount that possibility?

A When you put the whole case together, including the postmortem, there is no question that she was seeing a malignancy in my opinion.

Q Well, the postmortem is the autopsy report you're referring to?

A Correct.

Q The autopsy report doesn't make any finding of an endobronchial lesion; isn't that correct?

A I'm relating to the fact that a diagnosis of an adenocarcinoma of the lung was established, and therefore I say that she was seeing that process when she looked down

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into the lung.

Q But the cytology would indicate that she was not, wouldn't it, because none of it was possible for the presence of any malignant cells in the brushings, the washings, or the part of the biopsy; isn't that correct?

MR. YOUNG: You mean positive or possible?

Q Positive. Let me restate the question in case I've misspoken.

None of the bronchial washings, brushings or the biopsy of tissue that Dr. Turner obtained during the administration of the bronchoscope were positive for the presence of malignant cells; isn't that correct?

A That is correct.

Q And she took those washings, those brushings, and the biopsy from the areas that she was looking at through the bronchoscope that she describes in Exhibit 41; isn't that correct?

A That is correct.

Q So then isn't it also correct --

MR. YOUNG: Wait a minute. I'm

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sorry.

Q If I interrupted you, I'm sorry.

A Go ahead.

Q Isn't it also correct, Doctor, that it's possible that what she was looking at through the bronchoscope that she described in Exhibit 41 was not a malignancy?

A I can't believe -- I do not believe that she was not seeing a malignancy based on the total clinical picture including the radiographs through the postmortem established an adenocarcinoma of the lung.

Q What in particular in those documents would indicate to you that, as of the date of the bronchoscopy by Dr. Turner in early June, 1991, support the proposition that what she was looking at was not a malignancy?

A I don't know any processes that would do this that would not be malignant. You close off the bronchus intermedius and shut down the right lower and right middle lobes.

Q Extrinsic compression could, could it not?

A She describes seeing a neoplastic process meaning that this was not extrinsic impression.

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Q That's her conclusion that it's neoplastic, right?
A That's what she saw.
Q And you and I have agreed, have we not, that whether or not a neoplasm was, in fact, present can only be confirmed by a pathologist who examined tissue under a microscope, correct?
A That's correct.
Q And that didn't happen in connection with the specimens that Dr. Turner took at the time of her bronchoscopy, correct?
A That is correct.
Q Doctor, would you agree that endobronchial metastases can be confused with centrally placed primary lung carcinomas?
A Could you read that one more time?
Q Yes. Would you agree, Doctor, that endobronchial metastases can be confused with centrally placed primary lung carcinomas?
A That could occur.
Q Is adenocarcinoma a type of cancer that can arise in the largest number of organs in the body as compared to small cell and squamous

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cell carcinomas?
A Yes, sir.
Q What you agree, Doctor, that true primary bronchial adenocarcinomas are rare and often are derived from bronchial glands?
A Would you read that one more time?
Q Would you agree, Doctor, that true primary bronchial adenocarcinomas are rare and often are derived from bronchial glands?
A I have no basis to agree or disagree with that statement.
Q Would you agree, Doctor, it's more common for primary carcinoma of the pancreas to metastasize to the lung than for a primary carcinoma of the lung to metastasize to the pancreas?
A I have no basis to agree or disagree.
Q Doctor, do I understand that you attach some significance to your opinion that Mildred Wiley had an endobronchial adenocarcinoma as opposed to an adenocarcinoma in the periphery of her lung?
A Yes, sir.
Q What is that significance?
A An adenocarcinoma of the lung that

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originates in the periphery is more likely to be associated with metastatic disease, and thus it can be difficult to prove whether an adenocarcinoma that presents itself at the periphery of the lung would be primary or secondary tumor. In my opinion, when an adenocarcinoma of the lungs presents centrally in the bronchial disease, the likelihood that that is metastatic disease is much less.
Q And what's the significance of whether or not it's metastatic disease?
A Metastatic disease relates to where the primary originated.
Q Doctor, it's a fact, isn't it, that endobronchial adenocarcinoma can be metastases?
A It is possible for an adenocarcinoma to spread to the bronchial airway in the lung.
Q All right.
A Metastatic.
Q It's your opinion, Doctor, as I understand it that Mildred Wiley had primary lung cancer, right?
A Yes, sir.

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Q Assuming that she did, how long was her tumor, in your opinion, present in her lungs before she was diagnosed with cancer?
A Well, there is a history that suggests that she may have started smoking. I mean, she may have started coughing in a way that would not go away as far back as the fall of the year before.
Q Fall of the year before, being 1990?
A 1990. There is some suggestion that she became ill in the fall, and that was when the evaluation began, seeing the various doctors. So your question is how long?
Q With respect to your opinion that Mildred Wiley had primary lung cancer, how long, if your opinion is correct, was her tumor present in her lung before she was diagnosed with cancer? It takes some time for cancers to progress in the lungs?
A Right.
Q And I'm asking you based upon your experience, Doctor, in treating lung cancers and knowing about the subject of cancer in general, do you have any estimate for us as to how long her cancer was present in her

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lungs before she was diagnosed in June of 1991?
A Adenocarcinoma of the lung tends to be the slowest growing of the primary lung cancers, so it could have been as long as nine months.
Q And could it have been longer?
A It could have been longer.
Q It could have been a year or better?
A That's possible.
Q Two years or better?
A That's possible.
Q Three years or better?
A That's possible.
Q Four years or better?
A It's possible.
Q Five years or better?
A It's possible.
Q Six years or better?
A It's possible.
Q Seven years or better?
A There are histories that suggest that these tumors could develop over 20 years as long as 20 years, adenocarcinomas of the lung.
Q So if you're correct that she had a primary

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adenocarcinoma of the lung, she could have been began developing that cancer in her lungs more than 20 years prior to your June of 1991?
A It's possible.
Q Do you have any opinion, Doctor, as to whether or not the sale of cigarettes should be banned?
A Are you saying across all ages and --
Q Yes.
A I do not believe they should be banned for all individuals.
Q Let me ask you a question, here, Doctor, about -- let me ask you about some doctors' names that you -- whether you talked to them or had any discussions with them. Let me ask you this question. When was the last time that you talked to Dr. Kocoshis about Mildred Wiley's case that you can recall?
A At no time in my recollection.
Q Are you acquainted in any way with a professor George McCabe who is a professor at Purdue in West Lafayette?
A No, sir, not to my knowledge.
Q Are you acquainted in any way with a

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pathologist by the name of David D. Quirk?
A Not to my recollection.
Q Are you acquainted with a Dr. Steven Smith who practices in Indianapolis?
A Could I ask what type of practice?
Q He's a Director of Occupational Environmental Health Medicine at Community Hospitals.
A Yes, sir.
Q And how do you know him?
A He interned at Ball Memorial Hospital 15, 20 years ago. I see him periodically. We have been friends.
Q And when you say him periodically, how often do you see him?
A As often as once a year. It wouldn't average once a year, but --
Q Would those be on social occasions or professional occasions?
A Social.
Q Have you ever discussed Mildred Wiley's case with Dr. Steven Smith?
A No, sir.
Q Let me ask you this: Do you respect the opinions of Dr. Smith in the field of

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occupational disease and occupational medicine?
A Yes, sir.
MR. WAGNER: Let me review my notes and while I do so, let me relinquish the floor to Mr. Ohlemeyer, and I may be done. Go ahead, Bill.
DIRECT EXAMINATION
BY MR. OHLEMEYER:
Q Doctor, if you don't understand a question that I ask you, would you let me know?
A Yes, sir.
Q Would you define for me -- you used a phrase in the last deposition diagnosis of exclusion. Define that phrase for me.
A It's a term that relates to a diagnostic evaluation whereby you attempt to determine what the cause of a particular problem is, and on occasion you go about that in reverse inasmuch as you rule out in your thinking what possibilities could not do this. And then if you're left with one possibility or two possibilities or whatever, then that becomes your diagnosis and it's the diagnosis of exclusion. You've excluded

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other probable or possibly diagnosis.
Q With respect to the diagnosis of primary adenocarcinoma of the lung in Mrs. Wiley, was that a diagnosis of exclusion?
A Yes, sir.
Q Let me ask you this. Is determining -- I think you talked a little bit about this with Mr. Wagner. In your day-to-day practice as an oncologist, are you more concerned with obtaining a diagnosis from a clinician or a pathologist and then prescribing a treatment as opposed to determining the cause of that disease?
A Yes, sir.
Q Is determining the cause of cancer in an individual a relatively simple or a relatively difficult task from your perspective?
A It will sometimes be simple. It will sometimes be complicated. And sometimes you get no answer.
Q Prior to your involvement with this case, have you ever been asked to determine the cause of lung cancer in an individual?
A Are you asking in some type of formal

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discussion or a particular patient?
Q Well, let me put it to you this way, Doctor. Have you ever been asked -- separate and apart from the situation we are involved in here with respect to Mrs. Wiley, have you ever been asked in your day-to-day practice as an oncologist to use your background, your education and your experience to determine the cause of a lung cancer in a specific individual?
A You're asking me to recall a particular case, or are you just saying --
Q Yes. Have you ever done it before?
MR. YOUNG: You mean a legal case?
Q No. Doctor, my question is very simple. How often or how many times or ever have you been asked to determine the cause of lung cancer in a specific individual, whether it's for -- whether it's for lawyers or whether it's for a medical examiner or whether it's for the hospital quality control people or whether it's for another doctor? How many times have you done this before?
A Patients virtually always ask when they have

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a diagnosis of malignancy what caused it. They want to know how long they have had it and what caused it. So that is a common question. In terms of my practice do I involve myself with epidemiology and going into detail about what caused a particular problem, I would say my history taking will primarily involve did the patient smoke or not. If it's a known case of lung cancer, it might involve a history of asbestos exposure and that type of thing.
Q My question, Doctor, is -- let's break it down. How often during your practice as an oncologist does another doctor come to you and say, determine the cause of this cancer for me with reasonable certainty?
A You're saying lung cancer?
Q Let's say lung cancer.
A Rare.
Q Is it more likely than not somebody comes to you in your professional capacity and says, help me treat this case of lung cancer?
A Yes, sir.
Q Would you describe this type of exercise, trying to determine the cause of lung cancer

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in an individual like Mrs. Wiley to the exclusion of other causes to be a rather novel experience for you?
A The extent to which we have gone into detail about it is novel. But you often will approach a patient similar to the way that we approached her where you have some initial information, and then that points you in one direction or another. So that is not an uncommon practice to try to find out the origin because that will often dictate a different treatment, one origin versus the other. So that's commonly done.
Q Let me interrupt you there, Doctor. You don't need to know what caused -- we don't need to know the origin or the etiology of a lung cancer to prescribe a course of treatment?
A No, sir.
Q So my question to you is: How often -- and what you do for the most part each day, what you're trained in and what you're certified in, is the treatment of cancer; isn't that right?
A That's correct.

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Q In connection with your work as an oncologist, how often do you need to, or do you involve yourself in determining the cause or the etiology of a lung cancer in connection with your treatment of it?

MR. YOUNG: I object. He's answered that question. It's been asked already several times. It's slight changes.

A Rarely.

Q Now, Doctor, was Mrs. Wiley -- and let me make sure I understand, the conclusion that Mrs. Wiley had a primary adenocarcinoma of the lung was not a conclusion you reached before her death; was it?

A That is correct.

Q Had you made that determination before her death or had someone else made that determination before her death, might you have been able to prolong her life?

A As I said earlier, the clinical circumstances were such that there are very few adenocarcinomas that you can turn around in any short length of time with any kind of treatment. And particularly with regard to the diagnosis of adenocarcinoma of the lung,

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she would not have been someone in my opinion that in 1991 would have been treated with systemic chemotherapy, meaning toxic combination chemotherapy given her performance status to the extent what we said she was not capable to go down for an X-ray. And at that point you would try to put that information together and discuss with her family and the patient as to how aggressive they wanted to be or they wanted you to be.

There are no cancers, in essence, that don't have some potential for treating. But I believe that my thinking in her case was the only chance that we had to help her that she could tolerate was treatment not systemic, not chemotherapy. I don't envision that there would have been any attempt beyond that irrespective of what determination was made about the primary.

Q Doctor, what's the life expectancy for a stage four, primary adenocarcinoma of the lung?

A Three months.

Q What's the life expectancy for -- how do you

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stage them; one, two, three, four?

A Right.

Q What about a stage 3?

A Well, you need really more information than that. I mean, there are stage fours. I mean, any primary lung cancer, for example, in that period of time that was treated would have been a stage four. However, stage four simply means this: They are spread to some vital organ. In her case she had disease literally in multiple sites, and so her life expectancy, you know, was on the short side of that diagnosis. Stage 3 would be a rather different scenario. You would be more aggressive with a stage 3 which would imply it's confined locally within an organ system.

Q Am I correct, cancer was found in Mrs. Wiley's chest wall before it was found in her lung?

A True.

Q How many patients do you have that present with suspicious chest X-rays a negative bronchoscopy who are dead in six weeks as a result of primary bronchogenic carcinoma?

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A I can't give you a number. That's not uncommon.

Q Is it more common than not that a patient would have a negative bronchoscopy and be dead in six weeks as a result of a primary bronchogenic carcinoma?

A Based on the amount of disease that she had confirmed on bone scan, CT chest, et cetera, that would not be at all uncommon.

Q Well, maybe I'm not phrasing the question right. How many patients do you see in which the diagnosis of primary bronchogenic carcinoma is made within six -- well, how many patients do you see in which a diagnosis of primary bronchogenic carcinoma is made within a month or within four weeks of a negative bronchoscopy that die within two weeks?

A Any patient with as much cancer as she had is not going to live very long.

Q Can I interrupt you right there. With as much cancer as she had, as you put it, no one detected cancer in the lung prior to June 14; did they?

A I would argue that cancer in the lung was

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confirmed on her initial chest CT.
Q Doctor, did anyone diagnose carcinoma of the lung or cancer in the lung on the chest X ray or the CT?
A If you're asking when a pathologic diagnosis was made, yes, but no one would look at that CT chest and read it out as anything else than lung cancer.
Q No one read it out as lung cancer prior to June 14; did they?
A What was the impression?
Q Well, that's the point, right? All we have to do is go to the impression in the records, right?
A What number is that?
Q I don't want to waste your time, Doctor. All I want you to tell me is, what I need to do to find out how the radiologist read out the chest X-ray and the CT scan, is look for his or her report; don't I? Is that a question, Doctor, you can answer without looking at your notes?
MR. YOUNG: He's entitled to look at his notes.
Q The record should reflect that the question

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is pending. The Doctor is looking at Exhibit 2. My question, Doctor, is, can you answer that question without looking at Exhibit 2.
MR. YOUNG: He's entitled to look at his notes.
A Would you repeat the question?
Q The question is: Did anyone -- the first question was: Did anyone read out, as you put it, lung cancer as a result of any CT scan or chest X-ray prior to June 14? And my follow-up question was, I assume that all we would need to do to answer that question is look at the medical records and see what the radiologist said, right?
A That would be helpful.
Q Doctor, let me ask you this: How many patients have you been involved with who were on no code status, whose situation is terminal, who have limited prognoses, who are subjected to fine transthoracic biopsies?
A That's a common procedure.
Q Let me interrupt you there. Is it common --
MR. YOUNG: Do not interrupt him.

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Doctor, you have an absolute right -- you have an absolute right to answer the question and do it without being interrupted.
MR. OHLEMEYER: And he has an obligation to answer the question I ask, Counsel.
MR. YOUNG: And he can keep talking until he's blue in the face, but you have the absolute right to answer without interruption.
MR. OHLEMEYER: I've withdrawn my question, Counsel. You're wasting everybody's time.
MR. YOUNG: Thank you. You just now withdrew it.
Q How many of your patients who have been no code who have had -- who you have described as having a limited prognosis, who cannot be managed at home because of their situation, have been subjected to transthoracic needle biopsy? Can you think of one?
A It occurs. It would be unusual for a patient to be in the terminal phase of a malignancy to the point of being made a no

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code. Often by that time you will have established a diagnosis, and that particular scenario would be uncommon to proceed with additional diagnostic studies in that setting.
Q What would be the point of subjecting the patient to a procedure that I suspect you would agree with me has a risk attached to it -- that has some serious risks attached to it? What would the point of subjecting a patient to that kind of procedure be in that situation? The situation being a no code, terminal patient with limited prognosis? And again, Doctor, with all due respect, you're free to look at your notes, but can you answer that question without looking at your notes?
A I did not request that biopsy. Without looking at the record, I can't really comment as to that decision.
Q Let me ask it this way then: Is it fair to say that you did not request a transthoracic needle biopsy of Mrs. Wiley while you were caring for her?
A I need to look at the medical chart. Does

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anybody have it? I've just found my particular --
MR. YOUNG: Which one are you looking for?
THE WITNESS: We are looking for actually the progress notes, the entire progress notes and not just mine.
MR. YOUNG: See if that's it, Doctor.
A I would refer to the progress note of 6-11, the entry by Dr. Turner. "Cytology highly suggestive of squamous cell, given pain with coughing, et cetera difficulty obtaining biopsy of mass. Need to proceed with another avenue if possible. We will proceed with transthoracic biopsy. Correlation and definitive source of primary very important for treatment and long-term care of patient. The risk includes bleeding, collapsed lung explained to patient. She is agreeable."
So --
Q Let me ask you this, Doctor.
A -- I did not participate in that.
Q You didn't order it. You didn't need it to treat Mrs. Wiley at that point in time; did

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you?
A I do not record any comment as to whether I thought it needed to be done.
Q Well, even in hindsight, Doctor, you can agree with me that the results of that biopsy in a patient who is in the condition Mrs. Wiley was in wouldn't have affected how you treated her disease?
A That's true.
Q Okay. Doctor, am I correct there is no question in this case that Mrs. Wiley did not have a small cell carcinoma of the lung?
A I see no pathology report that suggests that.
Q And am I correct that when you and Mr. Wagner were talking about aggressive tumor types, histological cell types that are more aggressive than others, by aggressive you mean grow and spread more rapidly and are associated with a more rapidly deteriorating clinical course?
A From the time of the diagnosis to death.
Q So am I correct that a small cell lung cancer is generally associated with a more rapid decline in clinical course than an

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adenocarcinoma?
A Yes, and I mentioned that; did I not?
Q Yes. And that's an adenocarcinoma whether it starts in the lung or anywhere else?
A I don't think of any adenocarcinomas that were likely to move more rapidly than a small cell, undifferentiated or oat cell -- those are the same -- lung cancer.
Q So is it fair to say a rapid decline in clinical course is not a typical presentation for an adenocarcinoma of the lung or any other organ?
A That's true if you look at when the malignancy began and when the patient dies.
Q If you took the clinical picture, Mrs. Wiley's clinical picture, or the facts associated with her presentation, and you compared it to what the textbooks describe as a classic presentation for primary adenocarcinoma of the lung, would hers have been consistent with or inconsistent with a classic presentation for primary adenocarcinoma of the lung?
A I would say consistent with.
Q Well, why?

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A If you take the history going back to October of 1990 with cough on occasion of bringing up blood, at some point she began to lose weight. In March she developed back pain which was subsequently found or at least felt to represent a metastatic disease. So as far back as March you can argue that there was already spread to the bony skeleton and so widespread bony skeletal disease spread to the chest wall. To me it fits very well with an adenocarcinoma of the lung with central presentation.
Q Let's start with location within the lung. It does not fit with the majority of adenocarcinomas if you assume, as you do, that this was a bronchogenic adenocarcinoma. That fact in and off itself contrasts with the majority of primary adenocarcinomas of the lung?
A They tend to be more peripheral than central.
Q And just so we are clear here, there was cancer found in Mrs. Wiley's chest wall and in her bony skeleton as you've described

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it -- let me rephrase the question.
There was cancer diagnosed in her chest wall and bony skeleton before it was diagnosed in her lung?
A On what basis was it diagnosed in the bony skeleton? Are we talking pathology?
Q You're the one that told me a few minutes ago that there had been a spread to the bony skeleton in March. How do you know that what was observed in the bony skeleton in March was cancer?
A We don't.
Q So the most we can say is that there was cancer diagnosed in her chest wall before it was diagnosed in her lung?
A Say, when she was admitted to Ball Hospital based on bone scan, she already had widespread metastatic disease. X-rays of certain bones were consistent with lytic destruction. On that basis Dr. Dickerson went ahead with radiation therapy to the three sites so I -- my clinical review of the case is that she had bony metastatic disease as far back as March which didn't go away.

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Q Fair enough. But at the point where Dr. Dickerson does that, no one has yet diagnosed cancer in her lung?
A I do not have that information. We could look at the radiographic summary. Everybody has that.
Q Again, Doctor, it's just a matter of chronology; isn't it?
MR. YOUNG: Well, wait a minute. I guess I object to changing the question on him.
THE WITNESS: I would like to clarify as to when the radiation started.
MR. OHLEMEYER: Then have at it. Counsel, we will take as much time as you want, but I think the doctor would agree with me it's just a matter of simple chronology as to determining whether Dr. Dickerson reached his conclusion before or after the pathologist diagnosed cancer in Mrs. Wiley's lung; isn't that right, Doctor?
A That is correct.
Q Okay. Then we can deal with that some other time. My next question, Doctor, has to do with Exhibits 8 and 10. Do you have those

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in front of you?
A Yes, sir.
Q Do you see down on each page there are the initials, I suppose, of the typist or the person?
A Yes, sir.
Q Can you identify each of those for me by exhibit?
MR. YOUNG: He's already done that. I object.
Q He did it once with respect to one of them.
A I could not identify the stenographer on the 1-22 dictation.
Q Which is to say you don't know who typed it?
A I may know who typed it. I don't put together a name with those initials.
Q Are you sure -- I mean, my question is really was it typed here or could it have been typed somewhere else?
A My belief is that at that time all typing was in-house. We have since gone to -- I would say within the last two years to, you know, out. But until recently every word that was dictated at our office was done in-house.

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Q Was the June letter typed by Dr. Turner's secretary?
A By her secretary, DH?
Q Yes.
A DH, she's our chief stenographer who tells everybody else what to do.
Q Did Dr. Turner make any suggestions to you about changes you ought to make to that January draft?
A Not that I recall. I mean, I do not believe she did.
Q Do you recall if she reviewed it before you prepared the subsequent draft?
A I do not believe it -- I have no reason to think she would have reviewed it.
Q Dr. Songer, am I correct that any opinions that you as a doctor would have formed in connection with or at the time of your treatment of Mrs. Wiley would be contained as is practice in the records that you created at that time?
MR. YOUNG: I object to the form of the question. It's vague and confusing.
Q Do you understand the question?
A Ask it again.

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Q Is it fair to say that any opinions you formed about or in connection with your treatment of Mrs. Wiley would be contained in the medical records that you typically and, in fact, in this case created at or near the time of your involvement with her case, her medical case?
A I would not say that that's the case. It may or may not. It would not always follow that I would put every thought on the record.
Q Let me be more specific. Is it fair to say, Doctor, that any thoughts or opinions you formed about the diagnosis, the treatment or the cause of Mrs. Wiley's cancer that related to your involvement with her treatment would have been contained and are typically contained in the records you create in connection with and contemporaneous with such treatment?
MR. YOUNG: I object. That's been asked and answered.
A I would not say that that's always the case.
Q Well, in this case, what opinions did you form about the diagnosis, treatment or cause

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of Mrs. Wiley's cancer prior to her death that are not contained in your medical records?
MR. YOUNG: I object. We spent a day and a half going through all these opinions. They have all been asked and answered.
Q Do you understand the question, Doctor?
A I would say that my opinions relative to pertinent decision-making would have been expressed and explained in the chart.
Q And what decision-making would you have been involved in at that time?
A That this lady was too ill to consider any type of aggressive systemic chemotherapy, and therefore that was not considered an option. And I indicate that I discussed the case with the family. I did not put any detail as to that discussion on the chart.
Q In fact, there is no description or reference in the chart to any opinion you held at that time about her being too ill to undergo systemic chemotherapy; is there? Do you recall the question, Doctor?
A Would you ask me again?

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MR. OHLEMEYER: Why don't you read it back for him.
(The requested material was read by the reporter.)
Q Where in the record does it say that Mrs. Wiley was too ill to consider systemic chemotherapy, and it was not an option?
A I don't record that specifically.
Q That, in fact, is an opinion that you developed in connection with your conversation in May of 1993 with Dr. Turner about your state of mind at the time of Mrs. Wiley's treatment; isn't it?
MR. YOUNG: I object to that.
A No, sir.
MR. YOUNG: That's an improper question. It's argumentative.
Q Be that as it may, it's certainly not reflected or described in the chart that was prepared contemporaneous with your treatment of Mrs. Wiley?
A In my opinion, it's explicit because of what I didn't do. We did not treat her. I make an empiric decision which is a common thing for me to do or anyone to do if -- had this patient been a candidate for an aggressive

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regimen, that would have been discussed.
Q She was a candidate for tamoxifen though; isn't that right?
A I started tamoxifen citrate.
Q And that's all you did with Mrs. Wiley?
A I recommended radiation therapy.
Q Not to the lung?
A Not to the lung.
Q So the only treatment you prescribed for Mrs. Wiley was tamoxifen and radiation therapy to what you believe to be the bony metastases?
A That's correct.
Q Now, Doctor, during the meetings -- you described a series of meetings with attorneys from Mr. Wagner at the earlier deposition. Did you keep any notes or take any notes of those meetings?
A No, sir, none that I have.
Q Pardon me?
A None that I have run across. I don't remember making any notes.
Q Well, is your testimony that you may have taken notes that you don't now have or that you don't recall taking notes?

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A I do not recall taking notes, and I have not uncovered anything that would suggest to me that I had taken notes and had forgotten that I took the notes.
Q Did anyone tell you not to take notes at those meetings?
A No, sir.
Q Dr. Songer, am I correct that what you've referred to today, the notes you've referred to today, are the notes that we have previously marked as Exhibit 2 at your deposition?
A Yes, sir.
Q You've not made additional handwritten notes since the first session of the deposition; is that right?
A No, sir.
Q No, you haven't?
A I have not made any additional notes relative to this case since October 31st.
Q Okay. Referring again to the discussion, Dr. Turner describes in May of 1993 with you about Mrs. Wiley, you'll agree, won't you, Doctor, that that was approximately two years after Mrs. Wiley's death?

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A Yes.
MR. YOUNG: May of '93?
A Yes, sir.
Q And that the discussion, at least as it's been described to you, concerned the cause or etiology of Mrs. Wiley's cancer?
A That is correct.
Q And it's fair to say, isn't it, that the only reason for you to be involved in any type of discussion like that would be to assist either Dr. Turner or Mr. Wiley or Mr. Wiley's attorneys in prosecuting a claim as a result of her death?
MR. YOUNG: I object to the form of the question.
A No, sir.
Q Well, tell me what other reason. Well, let me rephrase the question.
Two years after Mrs. Wiley's death there is nothing you could determine about the cause of her death that would have impacted her treatment; isn't that right?
A That is correct.
Q Did anyone tell you there was any other reason why they were interested two years later in determining the cause of Mrs. Wiley's cancer beyond the role that kind of discussion or decision might play in a lawsuit like this?
A The basis that I recall being concerned about reviewing this had to do with the fact that I was going to be asked to give testimony as to my evaluation of the case. I do not recall, as I said earlier, what the technical, you know, what the specific aspects were? Was this a suit by, you know, by the family relative to the VA and employment? I do not recall that coming to my understanding.
Q Let me see if you recall this much: Dr. Turner was involved in the discussion, right?
A The discussion that she's talking about on May 24?
Q Yes, with you.
A Yes.
Q You and Dr. Turner had some discussion at some point in time after Mrs. Wiley's death, right?
A According to this.

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Q And at the time you were aware that there were lawyers involved in that discussion, right?
A Yes, sir.
Q And at the time you were asked to make some decisions or offer some opinions about Mrs. Wiley's cancer that you had not previously recorded in any medical records, right?
A That's correct.
Q All right. And how often are you asked to do that kind of thing, Doctor, after a patient's death?
MR. YOUNG: Objection. It's been asked and answered multiple times.
MR. OHLEMEYER: I'll rephrase the question.
Q Is it fair to say, Doctor, that for the most part when you get involved in that kind of exercise, a post-death discussion with other doctors or lawyers about the cause of a death, it involves some sort of litigation or claim being made about the death?
A That's correct.
Q All right. Doctor, can you tell us, do you

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know the addresses of the apartment complexes that you own or have an ownership interest in in Muncie?
A No.
Q Do you have a list of your tenants?
A No, sir.
Q Could you obtain something like that if it was necessary?
A I'm sure I could talk to the apartment manager.
Q How many apartment units do you think you own?
MR. YOUNG: I object. That is not relevant to this case. This is private business.
MR. OHLEMEYER: Well, Counsel, I disagree with you. And quite frankly, I think it's information we would be entitled to inquire in the venue of the voir dire.
MR. YOUNG: I disagree.
MR. WAGNER: Well, I don't want to debate the law with you.
MR. YOUNG: I don't either.
MR. OHLEMEYER: I got to believe I'm entitled to know whether a juror's

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landlord is a witness in the case.
A I believe it's a single apartment complex with 12 tenants.
Q Who is the property manager? Is it a company?
A No. It's an individual, and I think there are five co-owners.
Q And you don't know the address?
A I mean, I can get you there. But I can't tell you the address.
Q The newspaper, the Muncie paper, has described Dr. Turner as an anti-tobacco activist, among other things. Is that a description of her you would take issue you with?
A I think she is certainly an anti-tobacco add -- what was the word, advocate?
Q Advocate or activist?
A Activist relative to children smoking, and that's manifested by her efforts at school education.
Q Do you have any opinion, Doctor, as to who you think ought to win this lawsuit, bearing in mind that win is an imprecise word? But do you have any opinion as to who you think

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should prevail in this lawsuit?
A I think this is a very difficult case to defend apart from environmental exposure.
Q Well, describe for me the process by which you ruled out -- describe for me the process by which you would generally rule out risk factors for an endobronchial malignancy before arriving at an opinion about its cause, and then describe for me specifically how you did it in this case.
MR. YOUNG: I object to that question because it's been asked and answered. It's been covered for one and a half days, and it's a compound question.
A Would you ask that again?
Q Let me see if I can make it simple. You've suggested to me, I think, it's difficult to explain Mrs. Wiley's cancer but for to ascribe its etiology to environmental tobacco smoke. My question to you is: How hard have you tried? I mean, what have you done to try to rule out other potentially etiologies.
MR. YOUNG: Same objection.
A I believe I said environmental exposure.

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Q Fair enough, fair enough.
A And --
Q And I don't want to interrupt you, but by that you're trying to be specific in that environmental exposure doesn't necessarily mean environmental tobacco smoke but something she encountered in her environment including but perhaps not limited to environmental tobacco smoke?
MR. YOUNG: I object because the examiner has again interrupted the witness, and also the examiner has misstated the prior testimony of the witness.
Q Doctor, I don't want to put any words in your mouth. You're the one that corrected me about environmental exposure as opposed to environmental tobacco smoke, and I want you to tell me why you think that's a significant distinction.
A I have stated before that I am neither a pulmonologist nor an epidemiologist. I believe that this is a case of an adenocarcinoma of the lung with an endobronchial presentation. I believe that there is information that suggests that one

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possibility is environmental tobacco smoke. I believe that there is a suggestion in at least two of the articles referred to in Exhibit 6 that suggest that cases of ETS are more likely to be adenocarcinoma. I believe there is evidence for multiple sites of involvement along the tracheobronchial tree which is the typical circumstance you see where there is tobacco smoke exposure to the bronchial epithelium.

And I have by diagnosis of occlusion come up with no other diagnosis. So I would leave it to the epidemiologist to determine what airway irritant could have caused this. And I have not done extensive information with regard to the epidemiology history.

Q And, I take it, you would also leave it to the epidemiologist to describe for us the risk of developing lung cancer that's been observed in groups of people who claim a similar history of exposure to environmental carcinogens as Mrs. Wiley may have encountered?

A Well, I believe, as we have talked about, that is from the standpoint of some of the

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articles that I've brought that there are data that impact the increase in risk of cancer by ETS. And so I think that has to be a possibility that's dealt with in ruling out other possibilities.

Q So if I understand what you're saying, one thing you would leave it to the epidemiologist and you would expect the lawyers and perhaps the jury to consider in determining what the cause of Mrs. Wiley's cancer is the epidemiology that evaluates exposure to things other than environmental tobacco smoke and the resulting risk of disease?

A That would have to be taken into account.

Q Would you also have to take into account what epidemiology tells you about the risk associated with exposure to environmental tobacco smoke in the workplace in a nonsmoking woman who is not married to a smoker, who wasn't exposed to cigarette smoke as a child?

A I would not ignore information that I brought along that discusses increased risk in that regard. I have brought information

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that addresses that in a text that we use. And so I would not negate that as a possibility. I'm not prepared to say that that is not a possibility that I have considered in this case because of information that I have in medical oncology literature.

Q The text you just described for me, when was that published?

A Exhibit 6, June of 1991.

Q So you would certainly agree with me, Doctor, that there is information that may have been published since June of 1991 that you would want to review or consider in determining the level of certainty with which you hold any opinion you might hold about the cause of Mrs. Wiley's cancer?

MR. YOUNG: Object to the form of the question.

A I don't wish to go beyond what I've already presented.

Q Well, but what if there is information I could present to you that you haven't reviewed that suggests that there are things other than environmental tobacco smoke that

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are more likely to have caused an adenocarcinoma in a nonsmoking woman than environmental tobacco smoke? Wouldn't you want to look at that and consider it in determining what you or anyone else thinks is the cause of her cancer?

A I would be willing to review any information --

Q Well, wouldn't you --

A -- relative to this case.

Q Wouldn't you need to review that to assure yourself that you've ruled out other possible causes of Mrs. Wiley's cancer or to assure yourself that you have properly assessed the likelihood that her history of environmental tobacco smoke is responsible for her cancer?

MR. YOUNG: I object. That's argumentative.

A No.

Q Why not?

A I'm willing to let that be determined by the evidence and if it goes to court, by a jury.

Q So I'm just trying to understand, Doctor. Are you telling me that you are unwilling to

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consider evidence that suggests Mrs. Wiley was exposed to other environmental carcinogens --

MR. YOUNG: I object. I'm sorry go ahead.

Q -- in determining whether you've reached a reasonably certain opinion in this case?

MR. YOUNG: I object. That misstates his testimony.

Q Let me rephrase the question, Doctor. Are you telling me that your opinion about the cause of Mrs. Wiley's cancer would not change if I presented evidence to you that she was exposed to other environmental carcinogens that increase her risk of developing lung cancer as much or more than her history of exposure to environmental tobacco smoke?

A No, I'm not saying that.

Q So that's information you would certainly be willing to consider in critically analyzing your opinion about the cause of her disease, right?

A Yes, sir.

Q And it's information that might have the

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ability to affect if not change your opinion?

MR. YOUNG: I'll object. That calls for him to speculate.

A That is correct.

Q And to a certain extent, Doctor, don't you think it would be important for you to know whether there was evidence that Mrs. Wiley had actually been exposed to other environmental carcinogens besides her claim history of exposure to environmental tobacco smoke?

MR. YOUNG: Asked and answered multiple times.

A Yes, sir.

Q Doctor, can chemotherapy change or alter the cell structure of neoplastic and/or nonneoplastic tissue?

A Yes, sir.

MR. OHLEMEYER: I think that's about it. Give me a second here.

MR. WAGNER: Couple quick ones here, couple of omitted questions.

REDIRECT EXAMINATION

BY MR. WAGNER:

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Q Exhibit 6, the NIOSH report that you have there, where did you get that document?

A I have tried to remember, and I do not know. I believe that that was obtained through our Epidemiology Department at Ball Hospital.

Q Did Dr. Turner obtain that for you?

A I do not know.

Q When you say it was obtained through the hospital facilities, do you have an independent recollection of yourself requesting it to be obtained for you?

A I do not recall.

Q You don't recall one way or another?

A I don't recall.

Q Let me ask a different question. Do you recall when you obtained Exhibit 6?

A No, sir.

Q Did you obtain Exhibit 6 during this year, 1997?

A I do not recall. I reviewed it most recently, but I believe that I also had reviewed it back, we will say, at that period of time two years after her death. And so my recollection is that I've had it longer than a year.

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Q Your recollection is that you would have reviewed Exhibit 6 sometime during 1993?

A I believe.

Q You believe?

A I believe that that's correct.

Q Is there anything that clicks in your mind that suggests that belief to you, some association of some kind?

A When I began to review the material that I brought, it was obvious that I had read it in the past. I had read it before and so I believe that I had read it at the time when I was inclined to think that a case of one type or another was moving forward.

Q When you were writing these letters that we have looked at to Attorney Mr. Young, it's your belief that you would have had this NIOSH report, Exhibit 6; is that right?

A I believe that's correct.

Q Looking at 6, Doctor, there are markings in here, asterisks, parentheticals, marginal notes. Are all those yours?

A Yes, sir.

Q Do you remember when you put those on Exhibit 6? Would it have been within the

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two-week period that you were studying documents in preparation for your deposition?

A Some, yes. But as I say, when I began to prepare for the deposition there was evidence that I had read it prior to that.

Q Doctor, if you do any more work and form any more opinions that we have not covered in this deposition, will you advise us or plaintiffs' counsel, so that we can depose you about those matters?

A Yes, sir.

MR. WAGNER: I have nothing further.

MR. OHLEMEYER: My 20 minutes was only 30 minutes. Pretty good.

_____
JOSEPH MICHAEL SONGER, M.D.

STATE OF INDIANA)
)
COUNTY OF MARION)

I, Sally Gerlach, a Notary Public in and for said county and state, do hereby certify that the deponent herein was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the aforementioned matter;

That the foregoing deposition was taken on behalf of the Defendants; that said deposition was taken at the time and place heretofore mentioned between the hours of 8:00 a.m. and 6:00 p.m.;

That said deposition was taken down in stenograph notes and afterwards reduced to typewriting under my direction; and that the typewritten transcript is a true record of the testimony given by said deponent;

And thereafter presented to said witness for signature; that this certificate does not purport to acknowledge or verify the signature hereto of the deponent.

I do further certify that I am a disinterested person in this cause of action; that I am not a relative of the attorneys for any of the parties.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this_____day of_____, 1997.

_____
SALLY GERLACH, Notary Public

My commission expires:
August 9, 1998

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NOTICE OF DEPOSITION FILING

Dunn et. al. -vs- RJR Nabisco Holdings, et al.
DELAWARE County SUPERIOR Court
Cause No. 18D01-9305-CT-06

In compliance with Indiana Rules of Procedure, Rules of the Industrial Board or Federal Rules of Civil Procedure, pursuant to Indiana Supreme Court Order dated 10-1-86, you are notified of the filing with counsel for Defendants of the following deposition of Joseph Michael Songer, M.D..

_____
(Date of filing or mailing by certified mail)

cc:James H. Young, Esq.
William S. Ohlemeyer, Esq.
David O. Tittle, Esq.
Scott E. Schockley, Esq.
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